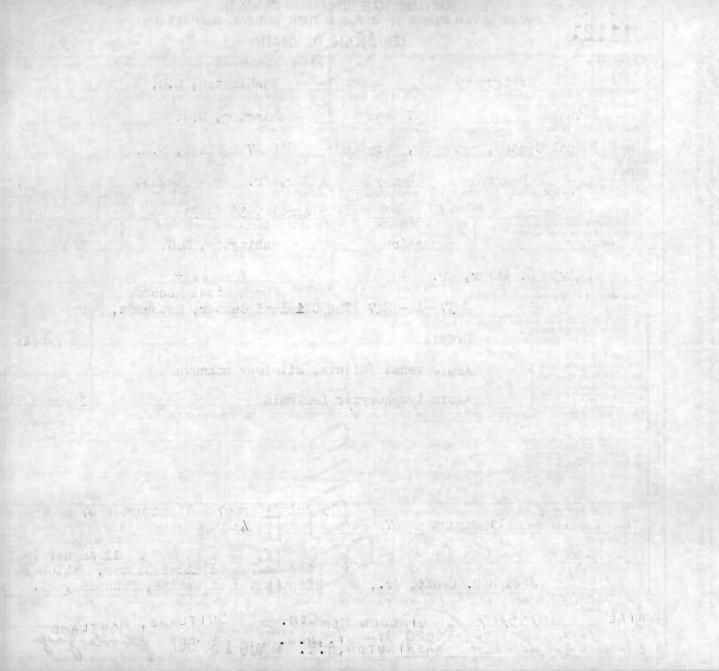
MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11722 **OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY b. COUNTY Montgomery Washington, D.C. MARYLAND b. CITY OR TOWN (If outside corparate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest tawn) Washington, D.C. Bethesda 27 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? within 72 The Clinical Center, Bethesda, Maryland 3816 17th Place, N.E. YES NO X 3. NAME OF 4. DATE Year ond completely DECEASED (Type or print) Ailer. Jr. Melvin Lerov DEATH August 19 S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED lost birthdoy) Months Male Negro WIDOWED DIVORCED 18 April 1936 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT physician o during most of working life, even if retired) **INDUSTRY** COUNTRY? Teacher Education Washington, D.C. USA 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME removol, Melvin L. Ailer. Edna Frav 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT The Medical Records (Yes, no, or unknown) (If yes give wor or dotes of service) 0 579-46-5247 The Clinical Center, Bethesda, Maryland Yes cremation, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONST AND DEATH

2 weeks IMMEDIATE CAUSE (o) Uremia Poge 4 moy be retoined by the hospitol or ottending physician. DUF TO Conditions, if ony, which gove (b) Acute renal failure, etiology unknown rise to immediate couse (o), DUE TO stoting the underlying cause this certificate has been as the (d) Acute Lymphocytic Leukemia vears PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS PERFORMED? YES X NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) foctory, street, office bldg., etc.) Not While ot work **DIRECTOR:** After 21. I certify that (X (this haspital) ottended the deceased fram 15 July , 19 67, to 11 August, 19 67, that (X (we) lost saw the deceased olive on 11 August 1967, and that death accurred at :20 M, from causes and on the date stated above. 22a./SIGNATURE 22b. DATE SIGNED STAFF PHYS. 12 August 1967 DIRECTOR M.D. director, page should be filed 22d. ADDRESS The Clinical Center. National 22c. PHYSICIAN'S FUNERAL D NAME (Type) Institutes of Health, Bethesda, Md. Joesph D. Croft Jr. MD 230. BURIAL/CREMATION, BURIAL (Specify) 23h DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 8/15/67 SUITLAND 9 2So. REC'D BY REGISTRAR 1967 WASHINGTON, D.C. DATAUG



9 1	MARYLAND STATE DEPARTMENT OF HEALTH ### A Provision of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
TOD CANTO	MEDICAL EXAMINER'S CERTIFICATE OF DEATH
FOR STATE	
HEALIN DEFT.	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 3. STATE b. COUNTY 4. COUNTY 4. COUNTY 5. COUNTY 6. COUNTY 7. COUNTY 7. COUNTY 8. COUNTY 8. COUNTY 8. COUNTY 9.
y is 3 ta 3 ta age at a a th.	MOTTIGETY - MARYLAND MOTTGEMENTY
2, and 3 ta PM3. Page partment af	b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town)
P. P	Kuril Postesiille. 2m. Pooles Ville. Aural 1
	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES IN A CONTROL OF THE PROPERTY O
ages ages ith fa	3. NAME OF First Middle Last 4. DATE Manth Day Year
24 haurs after death. In-ltem 18. Give Pages r's Office along with far es 1 and 2 with the State iny event within 72 hou	OF AUGUST 13 1967
Ign gin	S. SEX 6. COLOR OR RACE 7. MARRIED DE NEVER MARRIED TO 8. DATE OF RIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS
urs af 1 18. ce alc 12 wi	WIDOWED DIVORCED June 20 - 173 (20 yrs.)
thin 24 haurs encil in_ltem 18 miner's Office of pages 1 and 2 v in any event	10a. USUAL OCCUPATION (Give kind af wark dane during prost of working life, even interired) 10b. KIND OF BUSINESS OR U1. BIRTHPLACE (State or foreign country) 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?
n 24 il in-l ner's ges 1 any	13. FATHER'S NAME 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
within pencil xamine ile page	The months made in the many of the in many
d with the Exart Exart File and	1S. WAS DECLASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address
	(Yes, no, or Inknown) (If yes give war or dates of service) 218-34-703/ Mrs. Dries anderson Problewille
e execute pending" ef Medical ssit permit.	18. CAUSE OF DEATH (Enter anly one cause per line for (a), (b), and (c).)
be "pe "pe hief ansi'r	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Head. Sonseyand Death
uld vard vard le C le C al-tr an,	8 33 l DUE TO
sho e w a th ourie	Conditions, if any, which gove (b) (b)
This certificate shauld tote, writing the ward be farwarded to the Ch I be used as a burial-tro r to burial, cremation,	stating the underlying cause DUE TO
tifica riting ardec d as ial, c	, VI amenda
certiff, writh farwar used buria	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES NO 200. EXTERNAL CAUSE WAS 20th DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or Part
his e e to to	
DEPUTY MACCAL EXAMINER: This sessary, please execute the certificate, e funeral directar. Page 4 shauld be funy be retained far your files. FUNERAL DIRECTOR: Page 3 should be salth or its designated agent, priar ta	CAUSE OF DEATH
Local Examiner: ase execute the certification. Page 4 shauld ained far your files. IRECTOR: Page 3 should designated agent, pri	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, factory, street, office bldg., etc.)
XAM tre th ge 4 your page d age	9 dour a.m. 8/13 1967 While Not While of work
L EXA cecute Page far you MR: Pag	21. I certify that I took charge of the remains described above, held on Autopsy [], Inspection [X], Inquiry [X], and in my opinion
e execution in the signate signate is the signate i	deoth resulted from: Natural couses, Accident 🔀, Suicide, Homicide, Undetermined monner
Mired Jired Jired Jired Jired Jired Jee	ACTUAL OL BARRO CHIEF MEDICAL EXAMINER 22. DATE SIGNED
	M.D. ASSISTANT MEDICAL EXAMINER
DEPUTY MACCO	NAME (Type) DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county)
O DEPUTY ML. CA necessary, please ex the funeral directar. 5 may be retained O FUNERAL DIRECTO Health or its design	23a. BURIAL CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23b. LOCATION (City or Town) (County) (State)
1 1 2	furthe 3/13/6/ De. Marie Range Monte, Ma.
VR A15ME (5)	24. FUNERAL DIRECTOR ADDRESS
6M 1/66	William Dernibull All DATE AUD 10

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11124 11123 CERTIFICATE OF DEATH requires that the deoth certificate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY a STATE b. COUNTY b. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND Maryland Nontgomery
c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b ve corbon popers. P event, within 72 hour 12hrs 5min Gaithersburg d. NAME DF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) = e. IS RESIDENCE ON A FARM? YES NONE 3 NAME OF Middle 4. DATE Month Doy Year completely DECEASED OF (Type or print) 1967 DEATH NEVER MARRIED 8. DATE OF BIRTH MARRIED 5. SEX 6. COLOR OR RACE AGF (In years FUNDER I YEAR IF UNDER 24 HRS lost birthdoy) Months Dovs Hours and in ony WIDOWED DIVORCED 10-3-92 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) physician a during most of working life, even if retired) INDUSTRY COUNTRY? Live stock dealer
13. FATHER'S NAME Live stock Maryland J.S.A 14. MOTHER'S MAIDEN NAME or removal, Charles Arhold
15. WAS DECEASED EVER TO U.S. ARMED FORCES? Jefferson Emma 16. SOCIAL SECURITY NO. INFORMAN1 Address (Yes, no, or unknown) (If yes give wor or dotes of service) 20-09.5284 Mrs. Andrew J. Arnold Same as #2 cremotion, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).
PART I. DEATH WAS CAUSED 8Y: INTERVAL BETWEEN ONSET AND DEATH buriol-transit IMMEDIATE CAUSE (o) signed by **O HOSPITAL OR ATTENDING PHYSICIAN:** The low requires the Poge 4 may be retained by the hospital or attending physicion. DUE TD burial, Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse the State Dept. of Health prior to has been lost 19. WAS AUTOPSY PERFORMED? PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NDT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) NO certificate 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 38.) DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Not While Hour o.m. foctory, street, office bldg., etc.) of work ot work O FUNERAL DIRECTOR: After 21. I certify that (1) (this haspital) attended the deceased from . 19 67 to 8-13 1967, that (1) (we) last 8-12 saw the deceased alive an 8-13 19 67, and that death accurred at 2A M, fram couses and on the date stated above. 22o. SIGNATURE M.D. DIRECTOR PHYS PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) M. McKendree Bover. M D. 23c. NAME OF CEMETERY OR CREMATORY 23o. 8URIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) BEMOVAL (Specify) 8-15-67 Forest Oak Gaithersburg, Mont. Md. 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR Francis H. Barber Laytonsville, Md.

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	selected areas			
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11124

CERTIFICATE OF DEATH

11125

-		W - 100 - 10
	PLACE OF DEATH o. COUNTY	2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) o. STATE b. COUNTY
	Most gomery MARYLAND	Maryland Montgomer v
	b. CITY OR TOWN (If whiside corporate limits, c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If autside corporate limits, write RURAL on give nearest town)
	write RURAL and give nearest town)	Silver somos. 151
_	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)	L CYPETY ADDRESS
	Losshington Santarium & Hospita	1404 ON A FARM?
	NAME OF First Middle	Lost 4. DATE · Manth Doy Year
	OFCEASED (Type or print) Louis Anthony	Bagatti DEATH August 15 1967
S. :	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED	8. DATE OF BIRTH 1012 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS
	Male white WIDOWED DIVORCED	7-27-1848 (ust birthdoy) Manths Doys Hours Min.
	. USUAL OCCUPATION (Give kind af wark dane 10b. KIND OF BUSINESS OR	11. BIRTHPLACE (County & Stote, ar fareign country) 12. CITIZEN OF WHAT
Uri	ing most of warking life, eyen if retired) NDUSTRY Restaurant	Pennasylvania V.S.A.
3.	FATHER'S NAME	14. MOTHER'S MAIDEN NAME
	Just Orgald'	main a Fili
	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 12.	Maria Serventi
	as, no, ar unknown) (If yes give wor or dotes of service)	re Ann Bagatti 1220 Blair Mill Road
	No None 214-05-5742	Pt. Record. Silver Spring Maryland
	18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)	INTERVAL BETWEEN ONSET AND DEATH
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0) Care no no	Stomach - Metartages MAIA
	15/ DUE TO	0 00
	Conditions, if ony, which gove) (b)	
	rise to immediate cause (a), (Due To	
	stating the underlying couse (c)	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY
8	TAKE SI. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT KEEPED TO	PERFORMED?
8		YES NO >
CERTIFICATION	20a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRED.	(Enter nature af injury in Port I ar Port II af item 1B.)
	(IF EITHER, NOTIFY MEDICAL EXAMINER)	
SE	and the state of t	ACE OF INJURY (Home, form, 20f. (City or town) (County) (State)
MEDI	Hour o.m. While Not While fac	ctory, street, office bldg., etc.)
	21. I certify that (I) (this haspital) attended the deceased fram_	7-15-679_, tax-1567, 19_, that (1) (we) lo
Ì	saw the deceased alive an 2-1-19, and the	at death accurred at a M, fram causes and an the date stated about
	220 SIGNATURE	22b. DATE SIGNED
	Janes F anged wie	PD. ATTENDING MED. STAFF STAFF PHYS. DIRECTOR PHYS. PHYS.
	22c. PHYSICIAN'S NAME (Type) James Whitlock, M. D.	7717 and Ame Total And
23a	BURIAL CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR	R CREMATORY , 23d. LOCATION (City or Town) (County) (Stote)
	DEMOVAL (C)	
	rans-burial Aug 19, 1967 St. Mary's (emetery Cumberland Maryland Y 250, REC'D BY REGISTRAR 256, REGISTRAR'S SIGNATURE
14	TUNERTUDIFFTOR arter Ellen Color 8434 Georgia Augusta Georgia Augusta Englander & Pumphrey Inc.	DATE AUG 18 1967 FCIONES JUNE 1967
13/12	rner & Pumphrey Inc. 6434 george	ALL DATE ALLE LO DON

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbon papers. Pages 1 and 2. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 moy be retained by the hospital or attending physician. VR A15 (4 25M 1/6

a Subanita Long the their second Cara-Division (March 1997) and the contract of - Washing | Billiam

9-19-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH b. COUNTY ' o. COUNTY a. STATE delay is and 3 ta Pages 1, 2, and 3 ta with farm PM3. Page rince outside corporate limits, write RURAL and give nearest town c LENGTH OF STAY IN 16 b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Give Pages 1, YES NO D This certificate shauld be executed within 24 haurs after death. icate, writing the ward "pending" in pencil in Item 18. Give Pages NAME OF Year DECEASED OF DEATH alamoti 1961 (Type or print) the certificate, writing the ward "pending" in pencil in Item 18. Give 4 shauld be farwarded ta the Chief Medical Examiner's Office alang 9. AGE (In years 7. MARRIED S. SEX 6. COLOR OR RACE NEVER MARRIED DATE OF BIRTH lost birthday) Months Dovs Hours event within 72 haurs after death. 12 NOU. 1 WIDOWED 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of workingslife, even if retired) Greece etired - Wai 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 17. INFORMANT Address IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, po, or unknown) (If yes give wor or dotes of service) SOM: JOHNNY M. BALAMOTI ADELPHI INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
Cardian burial-transit ONSET AND DEATH Cardiorespiratory failure due to IMMEDIATE CAUSE (o) DUF TO any Aspiration of gastric contents Conditions, if ony, which gove rise to immediate couse (a). _= DUF TO stoting the underlying couse and 5 may be retained far yaur files.

TO FUNERAL DIRECTOR: Page 3 shauld be used
Health priar ta burial, crematian, ar removal, 19. WAS AUTOPS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION NO 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) PRIMARY XX or CONTRIBUTING [Deceased vomited and aspirated gastric contents. MEDICAL EXAMINER: CAUSE OF DEATH MEDICAL (Stote) 20e. PLACE OF INJURY (Home, form, (City or town) (County) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED foctory, street, office bldg., etc.) 6:00 PM p.m. Not While Hvattsville Pr. Geo. Md. 17/679 Page ot work ot work Home 21. I certify that I took charge of the remains described above held an Autopsy Inspection X. Inquiry . and in my apinian funeral directar. Homicide Undetermined manner death resulted from; Natural causes Accident Suicide CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE NAME (Type) the NAME OF (County) BURIAL CREMATION RTLINCOLN FMETERY 2Sb. REGISTRAR'S SIGNATURE 24.) FUNERAL DIRECTOR VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH 1 Physion of Statistical Research and Records, 301 W. Preston Street, Baltimore 1, Maryland CERTIFICATE OF DEATH

CERTIFICAT	E UF DEATH
1. PLACE OF DEATH a. COUNTY Montgomery	2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery
b. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b	c. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town)
Glen Echo Heights vears	Glen Echo Heights
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	d. STREET ADDRESS 6. IS RESIDENCE DN A FARM?
5445 Mohican Road	5445 Mohican Road YES ND
3. NAME OF DECEASED First Middle DECEASED (Type or print) EBB C. BARR]	LAST 4. DATE Month Day Year 7
5. SEX 6. CDLOR DR RACE 7. MARRIED NEVER MARRIED	
Male White WIDOWED DIVORCED	8. DATE OF BIRTH Mar. 26, 1892 9. AGE (In years IFUNDER 1 YEAR IFUNDER 2 HRS. Months Days Hours Min. Min.
10a. USUAL DCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?
Claim Examiner U.S.Govt	South Carolina U. S.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Ebb Barrington	Martha Britt
(Yes, no, or unkown) (If yes give war or dates of service)	INFORMANT Wife Address Same as Item 2.
	vivian B. Barrington Balle as Item 2.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: WOULD MUYACA	raid upartices mittill
DUE TO ON T	t to be x ligger
Conditions, If any, which gave rise to immediate (b)	me rear accuse
cause (a), stating the DUE TO WITH CLOSE	ram solirasis. Jeans.
	ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY
PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELIGIOUS CONTRIBUTING TO DEATH BUT NOT RELIGIOUS CONTRIBUTING TO DEATH DESCRIBE HOW INJURY OCCUPANT OF THE PROPERTY OF TH	PERFORMED?
20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCU	JRRED. (Enter nature of injury in Part I or Part II of Item 18.)
DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
	ICE OF INJURY (Home, farm, 20f. (City or town) (County) (State)
Hour a.m. p.m. 19 While Not While at work at work	ory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from	ep 1 6 196/ to Celly 11, 196/, that (1) (we) last
saw the deceased alive on Clun 11 196/, and tha	t death occurred at 1/145 M from the causes and on the date stated above.
22a. SIGNATURE	ATTENDING MED. STAFF 22b. DATE SIGNED
22c, PHYSICIAN'S A D	D. PHYS. DIRECTOR PHYS. 3
NAME (Type) CORYLAND	4400-49mSTNW Wash DE
23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETER'	
Burial 8-15-67 Parklawn Ce	
24. FUNERAL DIRECTOR ADDRESS DOD EDT A DIMPHDEY Both odd Marry	25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
ROBERT A. PUMPHREY, Bethesda, Mary	rland DATEAUG 2 1 1967 persones Jusques :

VR AI5 (4) 20M 1/65

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after MARYLAND (If outside corporate limits, write RURAL and give nearest town) LENGTH OF STAY IN 1b hours e. IS RESIDENCE ON A FARM? (If not in hospital, give street address d. STREET ADDRESS impletely f DATE Year Lost DECEASED (Type or print) DEATH any event AGE (In year IF UNDER 1 YEAR UNDER 24 HRS 7. MARRIED Months Doys Hours WIDOWED DIVORCED 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR burial, cremotion, or removal, and in during most of working life, even if retired) COUNTRY INDUSTRY physician FATHER'S NAME 14. MOTHER'S MAIDEN NAME 16. SOCIAL SECURITY NO Address mp, or unknown) (If yes give wor or dotes of service 1B. CAUSE OF DEATH (Enter only one couse per li PART I. DEATH WAS CAUSED BY: buriol-transit IMMEDIATE CAUSE (a) signed by **O HOSPITAL OR ATTENDING PHYSICIAN:** The low requires the Page 4 may be retained by the hospital or attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a) DUE TO stoting the underlying couse hos been State Dept. af Health prior ta SD PART H. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO WAS AUTOPSY PERFORMED? THE TERMINAL DISEASE CONDITION GIVEN IN PART certificote 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (Stote) 20c. TIME OF INJURY Month, Doy, Year (County) Hour 'o.m. factory, street, office bldg., etc.) Not While ot work 21. I certify that (1) (this haspital) attended the deceased fram and that death occurred at 53 PAM, fram causes and an the date stoted obove O FUNERAL DIRECTOR: saw the deceased olive on 220. SHOWATURE director, page 3 should be filed v 22d. ADDRESS University DATLOW NAME (Type) Silver Spring. Marvl 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION. 23b. DATE THEREOF (County) REMOVAL (Specify) Cemetery Parklawn Rockville, Maryland 250. REC'D BY REGISTRAR DATE AUG 3 1 15 24. FUNERAL DIRECTOR 2Sb. REGISTRAR'S

PUMPHREY. Bethesda. Maryland

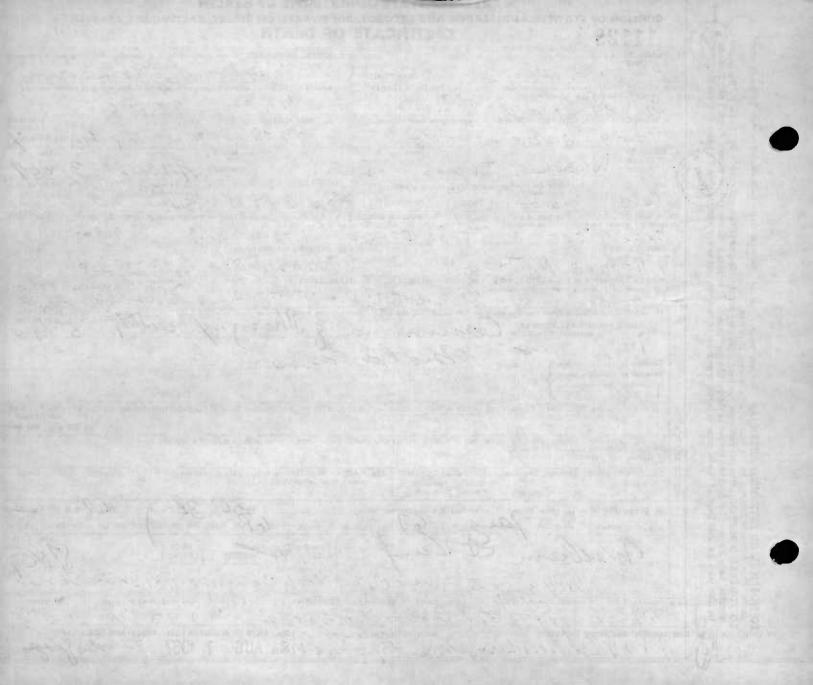
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The law requires that the deoth certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission). o. COUNTY b. COUNTY MARYLAND C. LENGTH OF STAY IN 16 b. CITY OR TOWN Moutside carparate limits, c. CITY OR TOWN (If autside corporate limits, write RURAL and give negrest town) write RURAL and give nearest down) 10-67 1mpsonulle d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO 12 ono vele int carbop NAME OF Middle Year Doy DECEASED LAUST 196 (Type or print) DEATH S. SEX 6. COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH IF UNDER 24 HRS last birthday) Months Doys Hours ond in any WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work dane 1Db. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) INDUSTRY ottending physicion (ermit. Then please Washington.

14. MOTHER'S MAIDEN NAME House wife wn home 13 FATHER'S NAME burial, cremotion, or removal, WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Groveleigh Drive (Yes, ng, orunknown) (If yes give wor or dotes of service) Eugene Alber None None INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit PART I. DEATH WAS CAUSED BY: Coronary occhrows IMMEDIATE CAUSE (o) signed by by the hospitol or ottending physicion. DUE TO Conditions, if ony, which gave mesular desea. rise to immediate couse (a), DUE TO prior to stating the underlying couse the 20 05 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) has NO K certificate Por 2Do. ACCIDENT WAS LINDERLYING ? 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dc. TIME OF INJURY Month, Doy, Yeor Hour o.m. 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, (City or town) (Stote) (County) foctory, street, office bldg., etc.) Not While of work ot work **DIRECTOR:** After all attended the deceased from ______, 19 44, ta_creg 10, 1967, that (1) (we) last Cree 6 1967, and that death occurred of 530. M, from causes and on the dote stated abave. 21. I certify that (1) (this haspital) attended the deceased from director, page 3 should should be filed with the saw the deceased alive an_ 22o. SIGNATURE 22b. DATE SIGNED MED. DIRECTOR 010-6 M.D. Zan 22c. PHYSICIAN'S 22d. ADDRESS O FUNERAL NAME (Type) James E Nolan. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL CREMATION 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Chestrut Grove Cemetery Herndon. Can 8434 DRyeoraia Avenue VR A15 (4) 25M 1/67 1 plung

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DIVISION OF STATISTICAL RESEARCH STON STREET, BALTIMORE 1, MARYLAND DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution: Residence before edmission) fung a. COUNTY b. COUNTY by the and 2 death. 1077 MARYLAND 0 me 5 Tay 100 b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL è write RURAL and give neerest town) Pages 1 a executed within d. NAME OF HOSPITAL OR NSTITUTION (if not in hospitel, give street eddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 21 b700 YES NO completely NAME OF Middle DATE Last DECEASED OF carbon (Type or print) DEATH HOMAS 19 DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED and lest birthday) Months Deys Hours event WIDOWED [DIVORCED certificate physician Silver 3 pring 11. remove 10e. USUAL OCCUPATION (Give kind of work BIRTHPLACE (County State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) any SUPETVISOR 23 please 13. FATHER'S NAME MOTHER'S MAIDEN NAME 5 aftending ome 10 Then 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT removal (Yes, no, or unkown) | (Ifyes give wer or dates of service) been signed by the permit. attending physician. 18. CAUSE OF DEATH [Enter only one cause per line for (a), INTERVAL BETWEEN ONSEL AND DEATH Ö PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) has been signed he burial-transit cremation, Conditions, if any, which geve rise to immediate cause DUE TO burial (e), steting the underlying causa last. the the hospital or certificate CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) I 19. WAS AUTOPSY 5 3 PERFORMED? NO Z use prior YES 20a. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) for OR CONTRIBUTING TI CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) detached MEDICAL 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED I 20e, PLACE OF INJURY (Home, farm, ! 20f. (City or town) (County) (Stete) factory, street, office bldg., etc.) Hour e.m. While Not While to et work at work p.m. DIRECTOR: , that (I) (we) les P saw the deceased alive on... shoul OR 22b. DATE 22e. SIGNATURE ATTENDING SIGNED death. Page 4 r PHYS. DIRECTOR PHYS. M.D. page with th 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) filed \ 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (Stete) REMOYAL (Specify) O To B 61 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S 27 & MESATE AUG VR A15 (4) 20M 5-63



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for.

**O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death

Page 4 may be retained by the haspital ar attending physician.

Jin by the funeral Sec. Pages 1 and 2 72 tours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

a. COUNTY A	2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission o. STATE // b. COUNTY	1
MONTGOMERY	MARYLAND /VEW JERSEY	
b. CITY OR TOWN (If autside corparate limits,	STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town)	
write RURAL and give regress town)	days MARGATE 67	. 3
d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street addres	ON A FAI	
JUBURBAN	The state of the s	10 X
3. NAME OF First Middl DECEASED	OF OF	-
(Type or print) S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MA	BECKER SPEATH HUGUST 196 AARRIED 18. DATE OF BIRTH 9. AGE (In years THUNDER) YEAR IF UNDER	
11	VORCED 12-8-88 Tast birthday) Months Days Hours	Min.
100. USUAL OCCUPATION (Give kind of wark dane during most al warking life, even if retired) 10b. KIND OF BUSINESS Hot Westry Busi		2
13. FATHER'S NAME	14. MOTHERS MAIDEN NAME	
France Becker	Dophia Schoenheig	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (II yes give war ar dates af service)	NO. 17. INFORMANT 5311 Flanders A	370
No 150 09 31	36 Walter E. Becker- son -Kensington, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:	INTERVAL BETWOONSET AND DE	EEN
IMMEDIATE CAUSE (a) Uremia	a 3 mo	AIII
The state of the s	hrosis and pyo-ureters, bilateral 3 mo	
rise to immediate cause (a), stating the underlying cause lost.	areinoma, prostate gland 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO	PERFORME	PSY D? IO 🔲
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	JURY OCCURRED. (Enter nature of injury in Part 1 or Part II al item 18.)	
20c. TIME OF INJURY Manth, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While of work of work	lactary, street, affice bldg., etc.)	tate)
21. I certify that (1) (this hospital) attended the deceased alive an 196	eased fram $7-3$, 19 67 , to $3-1$, 19 67 (I) (we have $3-1$ and that death accurred at $13^{3/2}$ AM, fram causes and an the date stated	
22a. SIGNATURE	M.D. ATTENDING MED. STAFF 22b. DATE SIÓNED DIRECTOR PHYS. 22b. DATE SIÓNED	
the Many lath		
2c. PHYSICIAN'S MAME (Type) John D. Maylath	50 W. Edmonston Drive, Rockville,	Md
NAME (Type) John D. Maylath 230. BURIAL CREMATION, BRANCIA Specify) 23b. DATE THEREOF Laurel	50 W. Edmonston Drive, Rockville,	ate)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely directar, page 3 shauld be detached far use as the burial-transit permit. Then please remave carbon shauld be filed with the State Dept. at Health priar ta burial, crematian, ar removal, and in any event, with VR A15 (4) 25M 1/67

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STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DE funeral and 2 death. death. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY a. STATE b. COUNTY after er Maryland MARYLAND Montgomery c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) OR TOWN of outside corporate c. LENGTH OF STAY IN 1b write RURAL and give nearest town) hours Chevy Chase bon papers, within 72 h INSTITUTION of not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE filled ON A FARM? 6919 Strathmore Street YES ND S completely we carbon p within NAME OF Middle Last DATE Month Day Year OF DEATH DECEASED event, 1967 (Type or print) AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. last birthday) | Months | Days | Hours | Min. executed DATE OF BARTH and con remove SEX 6. COLOR OR RACE 8. NEVER MARRIED 7. MARRIED any WIDDWED > DIVORCED 12. CITIZEN OF WHAT nttending physician a mit. Then please ru or removal, and in = 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) pe FATHER'S NAME death certificate MOTHER'S MANDEN NAME been signed by the attending the burial-transit permit. Then ir to burial, cremation, or remo Eolh 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMAN' Son Addres Wilton 16. SOCIAL SECURITY NO. 17. (If yes give war or dates of service) A.Bentley- Ridgefield. George INTERVAL BETWEEN CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c) ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) the hospital or attending physician. DUE TO Conditions, If any, which (b) gave rise to immediate DUE TO (a), stating the as th underlying cause last. this certificate has NO WAS AUTDPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) detached for use e Dept. of Health PERFORMED? CERTIFICATI YES V ND T 20a. ACCIDENT WAS UNDERLYING ☐ DR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) MEDICAL (State) 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) 20d. INJURY OCCURRED 20f. (City or town) TIME OF INJURY Month, Day, Year be de State Hour a.m. While Not While TO FUNERAL DIRECTOR: After director, page 3 should be should be filed with the State þ at work 19 at work be retained that (I) (we) last 21. I certify that (I) (this hospital) attended the deceased from and that death occurred at 5 7M, from the causes and on the date stated above. saw the deceased alive on 22b. DATE SIGNED 22a. SIGNATURE STAFF PHYS. ATTENDING PHYS. M.D. DIRECTOR Page 4 may PHYSICIAN'S 22d. ADDRESS 22c. NAME (Type) (State) LOCATION (City, town or county) BURIAL, CREMATION, NAME OF CEMETERY OR CREMATORY 23d. 23b. DATE THEREOF REMOVAL (Specify) Burial rlington Natl 25a. REC'D BY REGISTRAR FUNERAL DIRECTOR ADDRESS PUMPHREY, Bethesda, Maryland DATAUG VR A15 (4) 15M 4-64

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= = 0.17	11132 CERTIFICATE OF DEATH	1133
death.	1. PLACE DF DEATH HOLY CROSS HOSPIAL 2. USUAL RESIDENCE (Where deceased lived, If institution: R. a. COUNTY	esidence before admission
the full ges 1 after	MONIGOMERY MARYLAND PRINCE GE	orges
by the f	b. CITY DR TOWN (if outside corporate limits, write RURAL write RURAL and give nearest town)	and give nearest town
in I in I hour	SILVER SPRING, Md. TOLAYS KELFVIlle, MARYLAND 2070	
filled in by papers. Paggin 72 hours	d. NAME OF HOSPITAL OF INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS HOLV CROSS HOSPITAL 11354 Cherryhill Road	e. IS RESIDENCE DN A FARM?
nin hin man min min min min min min min min min mi	3. NAME OF First Middle Last 4. DATE Month	Day Year
executed within and completely remove cachon in any event, with	(Type or print) ADAM E. BERGER DEATH Aug.	1, 1967
executed win and comple in and comple in any event,	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years) IFUNDER	
and and	M WIDOWED DIVORCED 1//5/67 yrs.	17
	during most of working life, even if retired) INDUSTRY Holy CROSS HOSPITAL CO	TIZEN OF WHAT DUNTRY?
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requires that the death certificate be ding physician. been signed by the attending physician the burial-transit permit. Then please or to burial, cramation, or removal, and in	ALAN L. BERGER KAPEN MEANY	
e in	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address	
atte ermi	(Yes, no, or unknown) (If yes give war or dates of service) H's, Chart	
the day	18. CAUSE OF OEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
at the san the	PART I. DEATH WAS CAUSED BY: Internal hydrocephalus	
s th ysic igne rial-i	DUE TO	
g ph g ph en s en s bu o bu	Conditions, if any, which gave rise to immediate (b)	
ndin s the	cause (a), stating the underlying cause last. (c)	
law atte has se as	PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTDPSY PERFORMED?
The icate	Status post cerebral ventriculotomy, recent	YES X NO
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician director, page 3 should be detached for use as the burial-transit permit. Then please should be filed with the State Dept. of Health prior to burial, cremation, or removal, and it is the property of the please should be filed with the State Dept. of Health prior to burial, cremation, or removal, and it is the property of the please of the p	PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Status post cerebral ventriculotomy, recent 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18. (IF EITHER, NOTIFY MEDICAL EXAMINER))
HYS he		nty) (State)
NG P by t fter be d state	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED About a.m. While Not While at work	
NDI ned tuld the S	21. I certify that (I) (this hospital) attended the deceased from 1-2 (, 1967 to 1967)	that (1) (we) las
ATTE retail CTO Sho sho vith t	saw the deceased alive on 1967, and that death occurred at 8 M, from the causes and on the causes and on the causes and on the causes are caused at 8 M, from the causes and on the causes are caused at 8 M, from the causes and on the causes are caused at 8 M, from the 6 M, from the caused at 8 M, from the 6 M, fr	ne date stated above ATE SIGNED
DIRE 38 8 9 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	Oualian MWIlliams M.D. ATTENDING MED. STAFF DIRECTOR PHYS.	-2-67
TO HOSPITAL Page 4 may of FUNERAL Edirector, page should be fill	NAME (Type) Toughthan M. M. M. M. D. M. ADDRESS D. M. D.	Le Cha
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Pag dire sho	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or coursely)	inty) (State)
	24. FUNERAL DIRECTOR ADDRESS	S SIGNATURE
VR AI5 (4)	Holdberg Remed Home 4217- 5 to DATE AUG 7 1967 your	les judge
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death by the funeral Pages 1 aper PLACE OF DEATH
o. COUNTY Montgomery 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE b. COUNTY Maryland after MARYLAND Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If autside carparate limits, Wheaton and campletely filled in by the remove carban papers. Page in any eventawithin 72 hours 3 weeks Rockville d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 14106 Bauer Dr. Univ. Nursing Home Wheaton. Md. YES | NO x 3. NAME OF First Middle 4. DATE Manth Last Day Year DECEASED OF August Nellie Bittinger 67 Blanche 19 (Type or print) DEATH 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED Manths Dovs Haurs WIDOWED DIVORCED 9/26/1890 Female White 76 10a. USUAL OCCUPATION (Give kind of wark dane 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, ar fareign country) 12. CITIZEN OF WHAT and in a during most of working life, even if retired)
Housewife Own home the attending physician isit permit. Then please COUNTRY? USA Swanton, Md. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Francis Pritts Harriet Scooley 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 14106 Baner Drive (Yes, no, ar unknown) (If yes give war or dotes of service) 178-05-7452 Mrs. Verna Lindsay None No cremation, CAUSE OF DEATH (Enter anly one cause per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH signed by the burial-transit p PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO burial, Canditions, if any, which gave rise ta immediate couse (o), DUE TO stoting the underlying couse be retained by the haspital or attending **DIRECTOR:** After this certificate has been the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? CERTIFICATION Health NO YES for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (Caunty) (State) 20c. TIME OF INJURY Manth, Doy, Year factory, street, affice bldg., etc.) Not While at work at work pe 1961 1967, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram. . ta and that death accurred at 855 saw the deceased alive on. 19 6 M, fram causes and an the date stated above. director, page 3 sha shauld be filed with 22a, SIGNATURE 22b. DATE SIGNED M.D. PHYS. DIRECTOR PHYS. **ADDRÉSS** 22c. PHYSICIAN'S Page 4 may O FUNERAL NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (Caunty) (State) Latayette Memorial 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE ylen [ar y Charles VR A15 (4) DATAUG 1967 20 M 1/66 Silver Spring.

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 135 deoth. deoth. unerol 1 and 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY MARYLAND hours after c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest to (n) write RURAL day d. NAME OF HOSPITAL OR INSTITUTION (If not hospital, dive street address) IS RESIDENCE ON A FARM? ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 his d. STREET ADDRESS papers. any event, within 72 filled NO X corbon NAME OF Middle 4. DATE Doy Yeor and completely DECEASED 30 (Type or print) 19 DEATH IF UNDER S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH AGE (In years lost birthdoy) Doys Hours 1908 WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) and in COUNTRY during most of working life, even if retired) NDUSTRY School leacher 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removol, Robert H. Cook Minnie C attending permit. The 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) wer oprina. cremotion. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the buriol-transit p PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse os the prior to be retained by the hospital or attending hos been lost. WAS AUTOPS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PERFORMED? Health YES certificote Por 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, farm, (Stote) 20d. INJURY OCCURRED (City or town) (County) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg., etc.) While Not While of work TO FUNERAL DIRECTOR: After 1967 that (1) (44) las 21. I certify that (I) (this hospital) attended the deceased fram. 1965 should and that death accurred at 2 05 A M, fram causes and an the date stated above 1962, saw the deceased alive on 22b. DATE SIGNED 22o. SIGNATURE OR 0-M.D. PHYS DIRECTOR PHYS filed be filed 22d. ADDRESS 22c. PHYSICIAN'S O HOSPITAL NAME (Type) 205 director, should b 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) (County) (Stote) 23o. BURIAL, CREMATION REMOVAL (Specify) 2Sb. REGISTRAR'S' SIGNATURE 2So. REC'D BY REGISTRAR VR A15 (4) 25M 1/67 Juneral Home

Switcher Land Walter yaano iro il parage 33016 Supplies printed asolie Holy Cross Hospital 939: North Complaine North Blackishen Augs de on Dan 11, 1908 59 A 3 JI John Santa Santa A Sant

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 21 1 3 6 11135 CERTIFICATE OF DEATH death. pup PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. COUNTY Montgomery o. COUNTY Montgomery filled in by the fun papers. Pages 1 o hin 72 haurs after o Marvland MARYLAND OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b Bethesda. Bethesda d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) 4890 Battery 4890 Battery Lane Lane YES NOX 3. NAME OF Middle 4 DATE First Lost Year carbon DECEASED (Type or print) OF DEATH ELIZABETH BONHAG 19 67 10. event Aug. IF UNDER 1 YEAR | IF UNDER 24 HRS. S. SEX 9. AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH remaye 5 (st birthday) Months Days Haurs July 6, 1908 Female White and in any WIDOWED DIVORCED and 10a. USUAL OCCUPATION (Give kind of work done 1Db. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY Washington, D. S. Retired Govt 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, crematian, ar removal, Franklin C. Getzendanner Elizabeth Moffatt (Yes, no or unknown) (If yes give war ar dates of service) 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Husband Address Same as Item 2. 214-18-8176 George A.Bonhag INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) signed by the burial-transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if any, which gave rise to immediate cause (a). DUF TO stoting the underlying couse prior ta last. ds WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO DO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dd INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or tawn) (County) (State) 20c. TIME OF INJURY Manth. Dov. Year Hour 'o.m. factory, street, affice bldg., etc.) at wark ot wark 21. I certify that (I) (this haspital) affended the deceased fram director, page 3 shauld 1967, and that death accurred at 8 A M, from causes and on the dote stated obove. O FUNERAL DIRECTOR: saw the deceased alive an_ 22g. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. PHYS. DIRECTOR 22d. ADDRESS Washington 22c. PHYSICIAN'S WILLIAM L. HOWELL NAME (Type) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) Burial (Specify) 8-14-67 Rockville Cemetery Rockville, Maryland 25a. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURI 24. FUNERAL DIRECTOR **ADDRESS VR A15** PUMPHREY, Bethesda, Maryland 25M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11136 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 2, and 3 to PM3. Page o. COUNTY o. STATE b. COUNTY delay is and 3 to 0 MARYLAND b. CITY OR TOWN/If outside corporate limits mameri the State Deportment c. LENGTH OF STAY IN 16 CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town Write RURAL and give nearest town e. IS RESIDENCE ON A FARM? (If not in hospital, give street address) d. STREET ADDRESS Give Pages 1, should be forwarded to the Chief Medical Exominer's Office along with form NO X YES be executed within 24 hours ofter death. NAME OF Middle Lost Ooy Year DECEASEO DEATH 19 (Type or print) SEX 6. COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HR MARRIED NEVER MARRIEO Months birthdoy) in Item 18. Dovs Hours 72 hours after death. WIDOWED DIVORCED poges land2 BIRTHPLACE (Stote or foreign country) 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) MDUSTRY Home West Virginia 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME pencil Delphia Patrick H. Cuff permit. File .⊆ Thauer Avenue Address 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give was or dates of service) "pending" within Eugene S. Borgman ues INTERVAL BETWEEN 18. CAUSE OF OEATH (Enter only one couse per line burial-tronsit event PART I. DEATH WAS CAUSED BY ONSET AND OEATH IMMEDIATE CAUSE (o) This certificate should the word **OUE TO** any Conditions, if ony, which gove rise to immediate couse (o), .= DUE TO 0 stoting the underlying couse puo last. 050 19. WAS AUTOPSY PERFORMED? be used or removol, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO OEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) CERTIFICATION the certificate, NO 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 3 should PRIMARY Or CONTRIBUTING MEDICAL EXAMINER: CAUSE OF DEATH. cremotion, MEDICAL 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Your FUNERAL DIRECTOR: Page While Not While Page of work ot work 21. I certify that I taak charge of the remains described above, held an Autapsy Inspection Inquiry and in my apinian burial, director. death resulted from: Natural causes Accident Undetermined manner be retoined Hamicide CHIEF MEDICAL EXAMINER **ACTUAL** 22. OATE SIGNEO ASSISTANT MEDICAL EXAMINER prior SIGNATURE funerol DEPUTY MEDICAL EXAMINER **EXAMINER'S** Address But scill som or county) may Health NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL CREMATION (Stote) (County) 0 Trans-burial St. Ambrose Cemetery Cresaptowen. Maryland 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR anter. VR A15ME (5) Inc. 8434 Georgia Avenue Marley Judge Pumphrey 196 6M 1/67

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11138 ATTENDING PHYSICIAN: The low requires that the death certificate be executed, within 24 hours after death PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission o. COUNTY o. STATE b. COUNTY b. CITY OR TOWN (If outside proporte limits, write RURAL and give negrest town) MARYLAND within 72 hours after Pages c. LENGTH OF STAY IN 1b. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) ON A FARM NAME OF Year DECEASED 26 (Type or print) DEATH S. SEX 6. COLOR OR RACE 9. AGE (In years IF LINDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED lost birthdoy) Hours WIDOWED DIVORCED UNE 25 1883 rem ond in on 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired)
POST OFFICE WORKER **INDUSTRY** COUNTRY? ALABAMA U.S. A Govt-retired 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removo ELIZA beth IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT 30928 McKinley St. Daughter (Yes, no, or unknown) (If yes give wor or dotes of service 423-42-1182 Elizabeth B. Adams Washington. 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) by the hospital or attending physicion. DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse certificate hos been be detached for use as the State Dept. af Health prior to WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO SE 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Dov. Year (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While ot work O FUNERAL DIRECTOR: After 1961, ta Cung 26, 1967, that (1) (we) last 21. 1 certify that (1) (this hospital) attended the deceased fram_ Page 4 moy be retoined poge 3 should e filed with the Cung. 25 19 6 7, and that death occurred at 69 M, fram causes and on the date stated above. saw the deceased alive on. 220. SIGNATURE 22b. DATE SIGNED STAFF PHYS. M.D. DIRECTOR 746 K Street. 22c. PHYSICIAN'S JOHN E. MORRIS NAME (Type) Washington. 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) REMOVAL (Specify) Falls Church, Virginia 8-28-67 National Mem. Park 250. REC'D BY REGISTRAR 1987 Sb. 24. FUNERAL DIRECTOR PUMPHREY, Bethesda, Maryland VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

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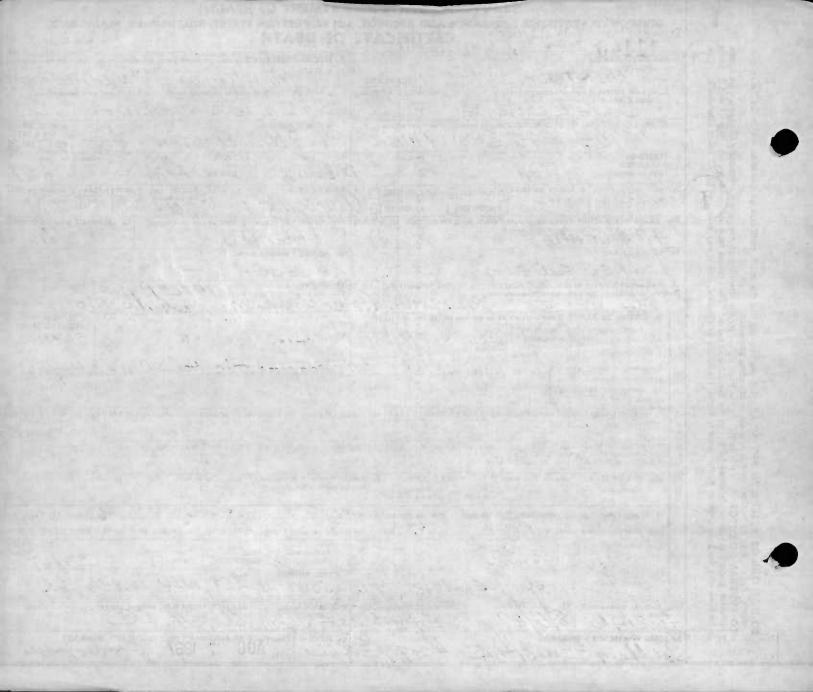
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W, PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11139 The law requires that the death certificate be executed within 24 haurs after death. funeral and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY Montgomery o. STATE Connecticut b. COUNTY filled in by the fune n papers. Pages 1 c ithin 72 haurs after d MARYLAND b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If gutside corporate limits, write RURAL and give nearest tawn) East Haven Rethesda 77 days d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? within 72 h The Clinical Center, Bethesda, Maryland 3 Pevetty Drive NO X NAME OF pan Last 4. DATE Year and campletely DECEASED (Type or print) remove carb 1967 Harrison Boyd. Jr. August 21. Horton DEATH S. SEX 6. COLOR OR RACE 7. MARRIED AGE (In years lost birthdoy) IF UNDER 1 YEAR | IF UNDER 24 HRS. NEVER MARRIED 8. DATE OF BIRTH Months Dovs Hours any e WIDOWED DIVORCED 30 July 1948 White Male 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11. B1RTHPLACE (County & State, or foreign country) 10b. KIND OF BUSINESS OR and in 12. CITIZEN OF WHAT COUNTRY? attending physician sermit. Then please **INDUSTRY** Massachusetts Student 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remaval, Phyllis Bishop Harrison H. Boyd. 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) 16. SOCIAL SECURITY NO. 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland 20014 None No burial, crematian, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: myocardial INTERVAL BETWEEN ONSET AND DEATH burial-transit IMMEDIATE CAUSE (0) Multiple hemorrhages, subdural, gastrointestinal, Page 4 may be retained by the haspital ar attending physician. DUE TO signed l Conditions, if ony, which gave Aplastic Anemia, idiopathic 4 months rise to immediate couse (a), **DUE TO** stoting the underlying couse priar to lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? YES NO After this certificate Po 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH be detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour a.m. Not While foctory, street, office bldg., etc.) ot work at work e deceased fram_5_June_____, 19_67, to21_August__, 1967, that (t) (we) las _19_67, and that death accurred at 8:15 M, fram causes and an the date stated above 21. I certify that (4) (this haspital) attended the deceased fram 5 June saw the deceased alive an Andrest 21 10 FUNERAL DIRECTOR: 220. SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS. 22 August 1967 M.D. director, page should be filed 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 22c. PHYSICIAN'S NAME (Type) David L. Lilien, MD. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) (Stote) BREMONAL (Specify) 8/25/67 Beaver Dale Mem. Pk. New Haven, Conn. 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR Bethesda, Md. 2So. REC'D BY REGISTRAR Pumphrev VR A15 (4) 25M 1/67 25

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH and 2 death. and 2 death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY 4 a. STATE b. COUNTY ontoomery MARYLAND laruland Montgomery by the Pages b. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b oon papers. Pag within 72 hours UPGAA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE DN A FARM? Ballard 1203 Rallard Street 1203 ND X YES etely pou NAME OF 3. First Middle with Last DATE Month Day Year DECEASED remove carb BRACEY 30 (Type or print) 16UST 1961 DEATH 5. SEX 6. CDLOR OR RACE 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 7. MARRIED NEVER MARRIED last birthday) Months Days Hours Temale. WIDOWED A DIVORCED August 11 1876 0 physician and please re Ξ 1Da. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? dousewite certificate Jun Home Maruland 13. FATHER'S NAME MOTHER'S MAIDEN NAME removal Charles Burch Maria Jurner 15. WAS DECEASED EVER IN U.S. ARMED FDRCES? transit permit. 16. SOCIAL SECURITY NO. 17. INFDRMANT Address (Yes, no, or unkown) (If yes give war or dates of service) 1203 Ballard St Marguerite the INTERVAL BETWEEN CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] law requires that the ONSET AND DEATH à al-trans PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) attending physician. signed burial-t DUE TO ERIOSCLEROTIC HEART Conditions, If any, which (b) peen gave rise to immediate the r DUE TD cause (a), stating the as th GENERALIZED ARTERIOSCLEROSIS underlying cause last. (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY for use Health The PERFORMED? certificate YES ND-5 PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING I DESCRIBE HOW INJURY OCCURRED, (Enter nature of Injury In Part I or Part II of Item 18.) this certil detached f te Dept. of DR CONTRIBUTING | CAUSE DF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE DF INJURY (Home, farm, (State) 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. While Not Whlie After at work at work retained should ith the S 21. I certify that (1) (this hospital) attended the deceased from. 1960 that (1) (we) last and that death occurred at M. from the causes and on the date stated above. DIRECTOR age 3 sho led with t saw the deceased alive on SIGNATURE 22a. be page STAFF M.D. DIRECTOR PHYS. PHYS. 4 may D HOSPITAL FUNERAL director, pa PHYSICIAN'S 22ć. 22d. ADDRESS SPRING. SILVER NAME (Type) Md. 23a, BURIAL, CREMATION.I 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOYAL (Specify) 1967 emetery UMAGIL 24. FUNERAL DIRECTOR **ADDRESS** 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE Pumphrey arner Juneral Home VR A.15 (4) 20M 1/65

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	MARYLAND STATE DEPA DIVISION OF STATISTICAL RESEARCH AND RECORDS, 30	ARTMENT OF HEALTH OI W. PRESTON STREET, BALTIMORE 1, MARYLAND
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MEDICAL	Hour a.m. While Not While fectory,	, street, office bldg., etc.)
2	print. "	PRIJ 7, 1964, to Pt 4, 1967, that (1)
	21. I certify that (I) (this hospital) attended the deceased from	eath occurred at A.M., from the causes and on the date state
	saw the deceased alive on 17.7 1 19.1 , and that de 22a. SIGNATURE	eath occurred at A.M., from the causes and on the date state
	Qual Kissler M.D.	ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. 7
	22- BUYERCIAN'S	22d. ADDRESS
	NAME (Type) ISRAEL KESS/ER M.D	5801-16-5t, NW. WASh, D.C
23	BURIAL, CREMATION, 236, DATE THEREOF 23c. NAME OF CEMETERY OF	CREMATORY 23d, LOGATION (City, lower county)
23	BURIAL, CREMATION, 23b, DATE THEREOF 23c. NAME OF CEMETERY OF	CREMATORY 23d, LOGATION (City, lowe or county)
U12:		23d. LOGATION (City, lowe or county) 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11142 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY ay is P.M.3. Page MARYLAND delay b. CITY OR TOWN c. LENGTH OF STAY IN 1b .carparate limits, write RURAL and give nearest tawn) and late Departr hasc d. STREET ADDRESS e IS RESIDENCE ON A FARM? form in Item 18. Give Pages NO X This certificate shauld be executed within 24 hours after death. Examiner's Office along with NAME OF Middle DATE Month Day Year DECEASED OF the N.M.N 30 1967 (Type or print) DEATH S. SEX IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED AGE (In years NEVER MARRIED Months last birthday) Days Hours within 72 hours after death. WIDOWED DIVORCED poges land 2 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country 12. CITIZEN OF WHAT during most of working life, even if retired) in pencil 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME File EDACT Levine 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address 2808 Abilene permit. word "pending" i (Yes, na, or unknown) (If yes give war or dates of service CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
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24. FUNERAL DIRECTOR KING DAVID MEMORIAL GARDEN FALLS CHURCH REGISTRAR'S VR A15ME (5) BERNARD DANZANSKY Y SONS-WASHINGTON Ullane 6M 1/67

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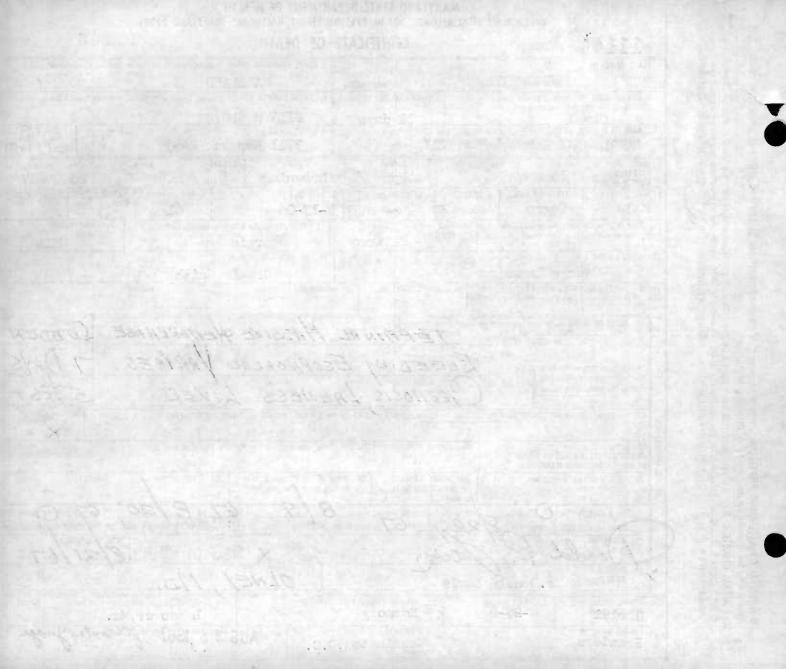
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11143 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death campletely filled in by the funeral lave carban papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY COUNTY 19amer remave carban papers. Pages I n anv event within 72 hours after MARYLAND c. LENGTH OF STAY IN 16 b CITY OR TOWN (If outside carporate limit outside carparate limits, write RURAL and give negrest town) write RURAL and give negrest town) MO.S en sin 4 IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) YES П NO and in any event within NAME OF First Middle DATE Month Year Dov DECEASED OF CATRICE 19 DEATH YU C 6 (Type or print) IF LINDER 1 YEAR IF UNDER 24 HRS. S. SFX 6. COLOR OR RACE AGE (In veors 7. MARRIED NEVER MARRIED lost birthdov) Months Dovs Hours WIDOWED DIVORCED and 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY 13. FATHER'S NAM 14. MOTHER'S MAIDEN NAME crematian, ar removal, 1/USS INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? permit. (Yes, no, or unknown) (If yes give wor or dotes of service) INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. DUE TO burial, Conditions, if ony, which gove (b) rise to immediate couse (o), DUF TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been directar, page 3 should be detached for use as the shauld be filed with the State Dept. af Health priar to last. 19. WAS AUTOPSY PERFORMED? OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION YES NO OR ATTENDING PHYSICIAN: 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) TIME OF INJURY Month, Day, Year 20f. (County) Hour o.m. Not While foctory, street, office bldg., etc.) 19 ot work 21. I certify that (I) (this hospital attended the deceased from , that (I) (we) lost deoth occurred of M, from couses and on the date stated above. sow the deceased olive on ond that 220. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. DIRECTOR PHYS. M.D. 22d. **ADDRES** PHYSICIANS NAME (Type) (County) 23c. NAME OF CEMETERY DATE THEREOF OR CREMATORY LOCATION (City or Town) (Stote) 23o. BURIAL, CREMATION, NATON REGISTRAR 1967 REGISTRAR'S SIGNATURE ADDRESS VR A15 (4) 20 M 1/66 Charle

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11144 CERTIFICATE OF DEATH **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 haurs after death. funerak and PLACE-OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY emer (own) papers. Pages 1 nin 72 haurs after b. CITY OR TOWN (If autside corporate limits, write RURA) and give nearest lown) MARYLAND by The Pages monta c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL od give neorest d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address, e. IS RESIDENC d. STREET ADDRESS filled ON A FARM? NAME OF carbon DATE Month Doy Year DECEASED (Type or print) DEATH even SFX 7. MARRIED IF UNDER 1 YEAR 6. COLOR OR RACE NEVER MARRIED DATE OF BIRTH 9. AGE (In years IF UNDER 24 HRS remave lost birthdov Months Doys Hours and in any WIDOWED DIVORCED and 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during mast of working life, even if retired) INDUSTRY COUNTRY? attending physician sermit. Then please AUSE W. 1.5.2 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME crematian, ar removal, IS. WAS DECEASED EVER IN U.S. ARMED FOR CES?
(Yes, no, or unknown)/ (If yes give wor or dotes of service) 16. SOCIAL SECURITY NO. 17. INFORMANT CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c). INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) be retained by the haspital ar attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO far use as the b f Health priar to b has been s stoting the underlying couse last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? NO certificate 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH State Dept. af detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While **DIRECTOR:** After 1967 to AC 16-29, 1967 that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased from ______ AUG, 27, 1967, and that death occurred at 57 M, fram causes and an the date stated above saw the deceased alive on 22o. SIGNATURE 22b. DATE SIGNED **ATTENDING** MED. DIRECTOR STAFF PHYS. M.D. PHYS ro HOSPITAL Page 4 may b 22c. PHYSICIAN 22d. ADDRESS TO FUNERAL director, shauld b BURIAL, CREMATION REMOVAL (Specify) LOCATION (City or Town) (County) (Stote) 24 FUNERAL DIRECTOR ADDRESS

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11145 CERTIFICATE OF DEATH 11144 leath. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY MONTGOMERY MONTGOMERY MARYLAND CITY DR TDWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH DE STAY IN 1b. c. CITY DR TOWN (If autside carparate limits, write RURAL and give nearest town) 11 days SILVER SPRING d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? completely filled in haye carban papers. ny event, within 72 h = MONTGOMERY GENERAL HOSPITAL 3711 Norbeck Road YES NO K Middle 3. NAME OF 4. DATE First Last Month Year Day DECEASED Joseph Nathan Browning 1967 20 (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH 9. AGE (In years NEVER MARRIED last birthday) Manths Haurs Negro Male 4-17-06 WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work dane 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or fareign country) during most of working life, even if retired) COUNTRY? INDUSTRY Retired and Georgia USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar removal, attending phys George Browning Cammie Smith 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dotes af service) 16. SOCIAL SECURITY ND 17. INFORMANT Address crematian, 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: signed by the burial-transit p ERMINAL MASSIVE HEMORRHAGE IMMEDIATE CAUSE (a) O HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the haspital ar attending physician. DUE TO ESUPHOGEAL burial, Conditions, if any, which gave rise ta immediate cause (a), DUE TO stoting the underlying cause as the ER HOSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) this certificate has of Health p PERFORMED? YES X NO 20g. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HaW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) detached (IF EITHER, NOTIFY MEDICAL EXAMINER) filed with the State Dept. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) 20c. TIME OF INJURY Manth, Day, Year factory, street, office bldg., etc.) Haur o.m. Nat While at work **DIRECTOR:** After 21. I certify that (1) (this haspital) attended the deceased fram. 1967, and that death accurred at 6: 15 Mm ram causes and an the date stated above saw the deceased alive an 22a. SIGNATURE DATE SIGNED M.D. DIRECTOR director, page should be filed 22d. ADDRESS PHYSICIAN'S FUNERAL NAME (Type) Dr. Donald Lewis 23b, DATE THEREOF 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23c. NAME OF CEMETERY OR CREMATORY (County) (State) REMOVAL (Specify) 8-25-67 Harmony L ndover, Md. 0 ADDRESS REC'DIBY REDISTRAR 10 775b. REVISIONES SICHALLI 24. FUNERAL DIRECTOR Washington, D.C. Fraziers DATE



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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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carban ent, wit		(Type or print) Marie Schnella Bruton OF DEATH China 17 1967
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attendi permit. ian, ar r		Mrs thamas the Triple - Whare
		1B. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) PART I DEATH WAS CAUSED BY ONSET AND DEATH ONSET AND DEATH
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signed by the burial-transit burial, crema		Conditions, if any, which gave) (b) Bilateral bullous pulmonary emphysema
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ar use Health	3	(terminal) bilateral bronchopneumonia PERFORMED? YES NO
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ECTOR: After this ce 3 shauld be detache with the State Dept.		220. SIGNATURE 22b. DATE SIGNED
% × 3		ATTENDING MED. STAFF DIRECTOR
□ ege		PHYSICIAN'S , 22d. ADDRESS
P b	,	NAME (Type) J. KICHARD COMPTON
TO FUNERAL DIRECTOR: After this director, page 3 shauld be detained and be filed with the State De	/	
rec nau		23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State)
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118	W	24. FUNERAL DIRECTOR ADDRESS 250. RECO-BY REGISTRAR'S SIGNATURE
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital ar attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11148 O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) o. COUNTY Montgomerv Florida MARYLAND c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If outside carporate limits, c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) write-BURAL and give nearest tawn) 20 days Sarasota d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? ve corbon popers event, within 72 Naval Hospital 270 Bearded Oaks Drive YES NO. NAME OF Middle 4 DATE Last Year Day DECEASED OF DEATH Edward BURKE :8 18 1967 Joseph (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. 9. AGE (In years S. SEX 6. COLOR OR RACE 7. MARRIED K B. DATE OF BIRTH NEVER MARRIED last birthdoy) Months Hours and commo 2 November 1907 Male Cauc WIDOWED DIVORCED inony 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? Larksville. Pa. USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremation, or removol Edward Joseph Burke Briget Connor 17. INFORMANT Chevy Chase 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes, never unknown) (If yes give worter dates of service Adele F. Burke 4722 Cumberland Ave Md. Unknown INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH Cirrhosis, liver IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse os the hos been last 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) YES 3 NO T 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Yeor Hour o.m. factory, street, office bldg., etc.) Not While of work to 18 August, 1967, that (1) (we) last 30 July 21. I certify that (I) (this haspital) attended the deceased fram_ saw the deceased alive an 18 August 1967, and that death occurred at 15.15 M, fram couses and on the date stated above. FUNERAL DIRECTOR: 22o. SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS. 18 Aug 1967 M.D. 22c. PHYSICIAN'S 22d. ADDRESS J.B. EMERY NAME (Type) Naval Hospital , Bethesda, Md. 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) REMOVAL (Specify) 8-22-67 Arlington National Arlington, Va. 9 25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67 DATE AUG R.A. Pumphrey, 7557 Wisconsin Ave, Bethesda

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits, write GURAL and give rearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTATUTION (IF hot in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? NOL 3. NAME OF Middle DATE Month Day Year DECEASED (Type or print) ederic DEATH HUGUS 19 7. MARRIED NEVER MARRIED AGE (In yeers | IF UNDER 1 YEAR | IF UNDER 24 HRS last birthday) Months WIDOWED [DIVORCED [10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT ease and it during most of working life, even if retired) INDUSTRY COUNTRY? FATHER'S NAME MOTHER'S MAIDEN NAME remova 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unkown) (If yes give war or dates of service) CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c),] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Cenditions, If any, which gave rise to Immediate DHE TO cause (a), stating the underlying cause last. as PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 119. WAS AUTOPSY PERFORMED? NO IX YES [20a. ACCIDENT WAS UNDERLYING [DESCRIBE HOW INJURY OCCURRED, (Enter nature of Injury in Part 1 or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, | 20f. (City or town) (State) (County) factory, street, office bldg., etc.) Hour a.m. While Not While at work at work 21. I certify that (I) (this hospital) attended the deceased from 1940 and that death occurred at 20 saw the deceased alive on 1960 M, from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. DIRECTOR 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) 23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) 24. FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR I 25b. REGISTRAR'S SIGNATURE VR A15 (4)

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FOR STATE	11148 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
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fter deoth. If any dela Give Poges 1, 2, and ong with form PM3. In the State Deportme	Washington Sanitarium & Hosp. 1535 Corroll Hue YES NO D
A Sith	3. NAME OF First Middle Lost 4. DATE Month Doy Year DECEASED OF
ive P wind wind wind wind wind wind wind wind	(Type or print) ENVIQUETO NONE CAPPETO DEATH 0 16 1967
offer olong	last birthday) Months Days Hours Min
hours o Item 18. Office ol Iond 2 w	Tenale white widowed 1-15-32 35 yrs.
offi offi	10a. USUAL OCCUPATION (Give kind af wark dane during most of warking life, even if retired) 10b. KIND OF BUSINESS OR life, even if retired) 11. BIRTHPLACE (State or fareign country) 12. CITIZEN OF WHAT COUNTRY?
24 in lin lirs es l	Murse Hospilal Echador Echador
nin preil pooge rrs o	13. FATHER'S NAME
d within in pencil Exomine File pog	Esteban Cabrera Carmen Caprera
ed in Est	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Address
xecuted within 24 hours or ding" in pencil in Item 18 Medical Exominer's Office or permit. File pages I and 2 within 72 hours offer death	unknown Hospital Record
should be executed within 24 hours ofter death. ne word "pending" in pencil in Item 18. Give Page to the Chief Medical Examiner's Office along with the buriol-transit permit. File pages land 2 with the State on any event within 72 hours ofter death	18. CAUSE OF DEATH (Enter anly one cause per line for (a), (b), and (c).)
pe "pe "pe "pe "pe "pe "pe "pe "pe "pe "	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonitis, viral ONSET AND DEATH
ord ord	525 X DUE TO
th the only	Conditions, if ony, which gave) (b)
the signature of the si	rise ta immediate cause (a), stating the underlying couse DUE TO
firot ting rded as q ond	lost. (c)
INER: This certificate should be executed within 24 hours ofter death. If a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, should be forwarded to the Chief Medical Examiner's Office along with form files. 3 should be used as a buriol-transit permit. File pages land 2 with the State Del tion, or removal, and in any event within 72 hours ofter death	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
This certicate, write be forward to be used removal,	PERFORMED? YES NO 20a. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
This icate, be fa	20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
R: ould s. ould ould	PRIMARY Or CONTRIBUTING CAUSE OF DEATH.
DEPUTY MEDICAL EXAMINER: This sessory, please execute the certificate, e funeral director. Page 4 should be framy be retained for your files. FUNERAL DIRECTOR: Page 3 should be realth prior to buriol, cremotion, or remo	20c. TIME OF INJURY Manth, Doy, Year Haur a.m. 20d. INJURY OCCURRED While Nat While factory, street, affice bldg., etc.) (City ar town) (Caunty) (State)
AAM be the the our	Hour a.m. p.m. 19 While at work of w
L EXA	21. I certify that I took charge of the remains described ebave, held an Autopsy X, Inspection X, Inquiry X, and in my opinio
MEDICAL EXA please execute director. Page estained for you DIRECTOR: Page r to buriol, crem	death resulted from: Natural causes X, Accident , Suicide , Hamicide , Undetermined manner
use ecto	CHIEF MEDICAL EXAMINER
Me dir ceta	SIGNATURE / SIGNATURE / SIGNATURE / SIGNATURE / ASSISTANT MEDICAL EXAMINER () 22. DATE SIGNED
UTY N ory, pla erol d be ret RAL D prior	EXAMINER'S Q - DEPUTX APPOICAL EXAMINER & \$116.1917
TO DEPUTY MEDICA necessory, please exthe funeral director. 5 may be retained to FUNERAL DIRECTO Health prior to buriar	NAME (Type) BELOEV N, NEAP M.D. Kowes (Sile a city pag or county)
o D D D D D D D D D D D D D D D D D D D	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CHMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote)
72 - + 25 -	Burran Guayaquil, Equador
VR A 15MF (5)	24. FUNERAL DIRECTOR WADDRESS WAShington, DC. 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
VR A15ME (5) 6M 1/67	Rinaldi Funeral Home, Inc. 7400 Georgia Ave DAW AUG 21 1967 Yellowles Yunge

AND HAVE THE PARTY OF THE PARTY CLANCE FOR A CHEST STEEL BOOK OF THE STANKING At the first of the second of The bearing the second of the Extrap (Interpreted and Interpreted) in our contractions of the second of the sec 1. ... ya. 2.1, c.2. c. 1.1.1 inal i ene al o e, In . Esocala yo

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11150 requires that the death certificate be executed within 24 haurs after death funeral s 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odnission) o. COUNTY MARYLAND the lease remove carban papers. Pages and in any event, within 72 hours aft c. LENGTH OF STAY IN 16 filled in by INSTITUTION (If not in hospital, give stille IS RESIDENCE ON A FARM? YES NO NAME OF Last DATE and campletely Year DECEASED (Type or print) DEATH AGE (In yeq IF UNDER 24 HRS 7. MARRIED DATE OF BIRTH NEVER MARRIED Months Doys Hours DIVORCED 10o. USUAL OCCUPATIO 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT COUNTRY 13. FATHER'S NAME MOTHER'S MAIDEN crematian, or remaval, attending phys 15. WAS DECEASED EVER IN 6.5. ARMED FORCES?
(Yes, no, or unknown)—(If yes give wor or dotes of service) 17. INFORMANT 16. SOCIAL SECURITY NO. IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: signed by the burial-transit p ONSET AND DEATH neumonia IMMEDIATE CAUSE (a) **O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires thu Page 4 may be retained by the haspital ar attending physician. DUE TO burial, Conditions, if ony, which gove (b) rise to immediate couse (o), DUE TO stoting the underlying couse we ueracnea far use as the State Dept. af Health prior ta last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NO IFICATI 200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item IB.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) TO FUNERAL DIRECTOR: After this Hour 'o.m. foctory, street, office bldg., etc.) While Not While of work ot work 21. I certify that (1) (this hospital), attended the deceased from 1966, to 196 2 that (1) (we) lost director, page 3 shauld shauld be filed with the 1967, and that death occurred at 11/2-M, from couses and on the date stated above sow the deceased olive on 220. SIGNATURE 22b. DATE SIGNED MED. DIRECTOR STAFF PHYS. 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) NAME OF BURIAL, CREMATION, (Stote) SOUTH GLEN FALLS 2So. REC'D BY REGISTRAR 2Sb. VR A15 (4) 25M 1/67 DATEAUG

The transfer of the state of th The sand the Boll of the sand the sand the sand the sand William Tair Walter Flews PAHLS the day of the trees of the second of the second September of the second second second Every Marches Land Butter Starten Markette Control of the Control of t

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY MONTGOMERY MARYLAND MARYLAND DONT GOMERU b. CITY OR TOWN (If outside corporate limits, write-RURAL and give nearest tawn) c. CITY OR TOWN (If autside carparote limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 15 an popers. Pag ETHESDA ISETHESDA .⊑ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? completely filled QUBURBAN YES NO DO NAME OF upo Middle Last 4 DATE Month Doy Year DECEASED OF DEATH (Type or print) GRORGE 9551DU 19 67 Nowley ever S SEX 6. COLOR OR RACE DATE OF BURTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED lost birthdoy Months Dovs Hours DIVORCED and in any WHITE WIDOWED JAN. 3. 1898 MALE 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT physicion a during most of working life, even if retired) COUNTRY? INDUSTRY MICHIGAN 60v.7. .54 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME or remova 17. INFORMANT Son WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 1701 KdreStreet, N.W. (Yes, no, or unknown) (If yes give wor or dates of service Washington, D. C. John Cassidy WW 261-80-5022 Yes on, 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN cremati Agute. ONSET AND DEATH Coronarg IMMEDIATE CAUSE (o) be retained by the hospital or ottending physician. DUE TO Cardio Vascular Disease burial, Conditions, if ony, which gove 4/2013 (b) rise to immediate couse (a), DUE TO stating the underlying couse has been lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) Health p NO YES this certificate 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 1B.) OR CONTRIBUTING CLAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) (County) foctory, street, office bldg., etc.) Hour o.m. at work 21. I certify that (1) (this haspital) attended the deceased fram. 1250 19___, that (I) (we) last 1967, and that death accurred at 843 M. fram causes and an the date stated above O FUNERAL DIRECTOR: saw the deceased alive an___ 22o. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. PHYS. be filed 7936 Old Georgetown 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS JOHN G. BALL Bethesda, Maryland should 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) REMOVAL (Specify) 8-14-67 Arlington. Virginia Arlington Natl Cem. Burial 2Sb. REGISTRAR'S SIGNATUR 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR VR A15 (4) 25M 1/67 PUMPHREY, Bethesda, Maryland Charles

HEALTH STREET BASES THE DEATHERS TITE. TO TO THE SECOND COME OF THE SECOND STATE OF THE SECOND STATE OF THE SECOND SEC THE SELECTION OF THE SECTION OF SELECTION OF TORREST A. CERROLET, Morthand, Party Land of All Services and Children and Children

Item 2d Film 392 9-1-6 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE	E 1 MADVI AND
11152 CERTIFICATE OF DEATH	3
1. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If Instit a. STATE b. COUNTY	
Maratanana	ONTGOMERU RURAL and give hearest town)
C:1 C:1 C:1 C:1	15.1
d. NAME OF HOSPITAL OR INSTITUTION (If not In hospital, give street address) d. STREET ADDRESS 2101 Hildarose 571 - University - Block - East	Drive e. IS RESIDENCE ON A FARM?
3. NAME OF First Middle Last 1.4. DATE Month	YES ND A
(Type or print) Eva Christine Catania DEATH Ang	23 1967
last birthday) M	UNDER 1 YEAR IF UNDER 24 HRS. onths Days Hours Min.
7 - Middle Widowed Divorced July 4, 1884 83 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR II. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT
Housewife Own Home Washington D. C.	COUNTRY?
13. FATHER'S NAME	
William A Keithley 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address	
(Yes, no, or unknown) (If yes give war or dates of service) 579-05-2380 A Olive L. Conpley Silver S	darose Drive
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thromboses (multiple)	3 yrs -1 m
conditions, If any, which \ (b) Generalized arteriosclerosis	20 yrs.
gave rise to immediate cause (a), stating the DUE TO	
underlying cause last. (c) PARTII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PA	ART 1(a) 19. WAS AUTDPSY PERFORMED?
Fracture hip Feb 1961	YES NO
PARTII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PARTIE 202. ACCIDENT WAS UNDERLYING A 202. ACCIDENT WAS UNDERLYING A 202. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	item 18.)
	(County) (State)
p.m. 19 at work at work	
21. I certify that (I) (this hospital) attended the deceased from 18 Aug , 1967, to 23 Aug saw the deceased alive on Not seen 19 , and that death occurred at 1255 M from the causes at	, 19 <u>67</u> , that (I) (we) las
22a. SIGNATURE	22b. DATE SIGNED
M.D. PHYS. DIRECTOR PHYS.	23 Aug 1967
22c. Physician's NAME (Type) John D. Griswold, M.D. 4830 V 9t M.W. D.	
23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town REMOVAL (Specify)	n or county) (State)
Burial August 24 1967, Arlington Nationa Cem Fort Much 24. FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR 25b? REG	ISTRAR'S SIGNATURE
Harner E. Pumphrey Tyneral Home Silver Spring. Mate AUG 2 0 1961 /	cherries judges

ve and the second secon The second secon The state of the s Land of the contract of the co Company of the contract of the The Manual Services of the Control o eta patrioli e de la companya de la sendall out held to by the first of a deal and amount devices were because treatment in south MARYLAND STATE DEPARTMENT OF HEALTH

VR AL5 (4) 20M 1/65

to be that it may be made to be a second of the second of anima tovila La side tax 1/1 and a similar -26 -52.61/6/1 and I was a second the control of the Berestin melantim to the first All harder classic course that all has been been a water An constant variants like bil collye use furteral lone Wachington, D. u. . Der a rose

		Division of STATISTICAL RE	ESEARCH AND RECORDS, 301	W. PRESTON STREET, BA	ALTIMORE, MARYLAND 21	201
- 0		11154	CERTIFICATE	OF DEATH	11	155
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death etained by the hospital ar attending physician. CTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral should be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 3 with the State Dept. af Health priar to burial, crematian, ar remaval, and in any event, within 72 hours after death		PLACE OF DEATH MONTGOME	EPY MARYLAND	2. USUAL RESIDENCE (Where do o. STATE MARYL)	eceosed lived, if institution: Resider b. COUNTY	nce before odmission) ONT.
haurs aften by the s. Pages hours aft		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	C. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside co	SPRING M	BEXBED.
in 24 ha iilled in 1 papers. hin 72 ha		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospit	tol, give street oddress)	d. STREET ADDRESS R4435 BE	IL PRE ROAD	e. IS RESIDENCE ON A FARM? YES NO
physician and campletely filled in en please remove carban papers.		NAME OF DECEASED (Type or print) NAME OF LURA	ANGELINE (ATH 8	Doy Year 31 1967
executed and cample emave cany evel	5	SEX 6. COLOR OR RACE 7. MARR EMALE WHITE WIDOW	VED DIVORCED	. DATE OF BIRTH' 3-9- 1880	9. AGE (In yeors lost birthdoy) Months	Doγs Hours Min.
ate be executician and camilease remave	106 dur	. USUAL OCCUPATION (Give kind of work done ring most of working life, even if retired)	b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State,	or foreign country) 2K STATE 12. CC	OUNTRY? USA.
equires that the death certificate be physician. signed by the attending physician arburial-transit permit. Then please rburial, crematian, ar remaval, and in	13.	FATHER'S NAME OSIAS WOOD		14. MOTHER'S MAIDEN NAME		o N
ne death ce attending permit. The	1S. (Ye	(a)	16. SOCIAL SECURITY NO. 17. III. 10. 220-54-2097	AUGHTER	SAME AS	ABOVE
lat the 1. V the a Insit pe		18. CAUSE OF DEATH (Enter only one couse per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	e for (o), (b), and (c).)	CARDIAL	/SCHEMIA	INTERVAL BETWEEN
equires that the physician. signed by the burial-transit purial, cremati		Conditions, if ony, which gove)	TERMINAL F	DLM. CON	gESTION.	TERM.
ding photon signature of the properties of the p		rise to immediate couse (o), stating the underlying couse (c) DUE TO	4.5. C V.D.			YRS.
4: The law re ar attending the has been ruse as the saith priar to	ATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION FOR THE SITE OF		HE TERMINAL DISEASE CONDITION 1 PHYSENA -	GIVEN IN PART 1(0) UREMIA	19. WAS AUTOPSY PERFORMED? YES NO
SICIAN: The law respiral ar attending I ertificate has been seed far use as the bear at Health priar to b.	CERTIFICATION	20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I o	r Port II of item 18.)	
OR ATTENDING PHYSICIA be retained by the hospital DIRECTOR: After this certific el 3 shauld be defacted fo el with the State Dept. af H	MEDICAL	Hour o.m.	Od. INJURY OCCURRED While Not While foctor	E OF INJURY (Home, form, ory, street, office bldg., etc.)	20f. (City or town) (C	ounty) (Stote)
ENDIN The by R: After old be the Stat		21. I certify that (I) (this haspital) at saw the deceased alive an	ttended the deceased from	HU9UST, 1962 death accurred at 12	ta 8/3/, 19 M, fram causes and an	61, that (1) (we) last the date stated above
OR ATI	(220. SIGNATURE	cuis M.C		STAFF -	DATE SIGNED / 31/67
		22C. ANYSICIAN'S NAME (Type) DONALD	R. LEWIS	700 CLOVE	RLY ST. SILI	IERSPR. Md
ro Hospital Page 4 may ro FuneRal director, pag shauld be fil	230	o. BURIAL (REMATION, REMATION) 23b. DATE THEREOF Sept. 2 19		· ·	d. LOCATION (City or Town)	(County) (Stote) New York
VR A15 (4)	24	4. FUNERAL DIRECTOR Francis H, Barber	ADDRESS Laytonsville	2So. REC'D BY RI	GISTRAR 2Sb. REGISTRAR'S 7 1967 William	

MARYLAND STATE DEPARTMENT OF HEALTH

"eloval Sept. 2 1967 arrenacure Was well gradulering rencis H, sorber Lagtonaville to.

Į.	tems 18&21 Film 393 MARYLAND STATE DEPARTMENT OF HEALTH 0-2-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
ÂTE	11155 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	156
DEP	PLACE OF DEATH o. COUNTY Montgomery MARYLAND 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence o. STATE Maryland b. COUNTY Montgomery	before odmission)
	b. CITY OR TOWN (If autside carparate limits, write RURAL and give write RURAL and give nearest tawn)	nearest tawn)
-	Takoma Park d. NAME OF HOSPITAL OR INSTITUTION (II not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
71	Washington Sanitarium & Hospital 5206 Elsmere Avenue	ON A FARM? YES NO X
	NAME OF Last Middle Let FI-SZ 4. DATE Manth	Day Year 24 19 67
	. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years IF UNDER 1	
	0a. USUAL OCCUPATION (Give kind of work dane uring most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or fareign country) INDUSTRY Waryland 12. (ITIZ	ZEN OF WHAT
	3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	
-	Friederich von Versen Julia ? IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address	
2	(1) Social security No. 17. Information (1) Yes, no ard unknown) (1) yes give war ar dates af service) 577-46-7680A Hosp. Chart	
event within 72 hours	IB. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute bronchopneumonia,	INTERVAL BETWEEN ONSET AND DEATH
	49/X DUE TO hilateral: Anteniosaleratio	
	rise ta immediate cause (a), stating the underlying couse DUE TO	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g)	19. WAS AUTOPSY PERFORMED?
1	20b. DESCRIBE HOW INILIRY OCCURRED. (Enter nature of injury in Part L or Part II of item 18.)	YES NO
	PRIMARY ar CONTRIBUTING	
	20c. TIME OF INJURY Manth, Day, Year Haur o.m. 19 While at work at work 19 day of the control of	nty) (State)
	21. I certify that I took charge of the remains described above, held an Autapsy x, Inspection Inquiry	and in my opinion
	death resulted from Natural causes 🗵, Accident Suicide 🔲, Hamicide 🔲, Undetermined manner	
	ACTUAL SIGNATURE Lead M.D. ASSISTANT MEDICAL EXAMINER Wheaton,	22. DATE SIGNED
2	EXAMINER'S NAME (Type) Belden R. Reap, M.D. DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county)	11967
2! =	·/	County) (State)
ot	24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland DATAUG 28 1867 25b. RECUBERAR'S ST.	NATURE JUNGE
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11157 11156 requires that the death certificate be executed within 24 hours after death. . PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY MARYLAND b. CITY OR TOWN (If autside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carperate limits, write RURAL and give nearest town) write RURAL and erve negres town d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? filled YES NO NAME OF corban Middle DATE Lost Day Year DECEASED (Type or print) 6 DEATH 19 S. SEX 6. COLOR OR RACE IF UNDER 1 YEAR IF UNDER 24 HRS MARRIED NEVER MARRIED DATE OF BIRTH AGE (In years last birthday Months Doys Hours Negro and in any WIDOWED DIVORCED and 100. USUAL OCCUPATION (Give kind af wark dane during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Caunty & Stote, or fareign country) 12. CITIZEN OF WHAT INDUSTRY 13. FATHER'S NAME 14. MOTHER'S MAIDEN WAME removal 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, na, ar unknown) (If yes give war ar dotes of service 0 cremation, CAUSE OF DEATH (Enter only one cause per line for (o), (b), PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-tronsit ONSET AND DEATH IMMEDIATE CAUSE (a) p DUE TO signed Conditions, if any, which gove rise ta immediate cause (a), DUE TO stating the underlying cause hos been OR ATTENDING PHYSICIAN: The low PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? CERTIFICATION 3 YES NO TO FUNERAL DIRECTOR: After this certificate 10 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept. 20e, PLACE OF INJURY (Home, form, (City ar town) (State) 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED (Caunty) factory, street, office bldg., etc.) Not While at wark 21. 1 certify that (1) (this haspital) attended the deceased from 19 6 /a to. 2, 19 (Ahot (1) (we) los I Tand that death occurred at I M, from cases and an the date stoted above saw the deceased alive an Tolaca 19 19 22a. SIGNATURE 22b. DATE SIGNED director, poge 3 should be filed v M.D. DIRECTOR PHYS. TO HOSPITAL (Poge 4 may b 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) 230. BURIAL CREMATION DATE THEREOM 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City of Town) (State) (County) REMOVAL (Specify) 24. FUNERAL DIRECTOR REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATU VR A15 (4) 25M 1/67

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	17	MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
	3/	11157 CERTIFICATE OF DEATH Reg. Dist. No.
W	1.	PLACE OF DEATH COUNTY MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission of the country of the
		c. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn)
	-	SILVEY Spring WASHINGTON 1. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE
90		Alther Woodland NURSING HOME 8000 - PARKSIDELANE, N.W YES NO D
8		NAME OF DECEASED Type or print) Edit T. DAVENPORT Lost 4. DATE OF DEATH 8 3 1967
	52 5	EX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years lost birthdoy) Months Doys Hours Min.
	10a	USUAL OCCUPATION (Give kind of wark done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or foreign country) 12. CITIZEN OF WHAT COUNTRY? 13. BIRTHPLACE (Stole or foreign country) 14. CITIZEN OF WHAT COUNTRY? 15. W. TZELLAND
	13.	FATHER'S NAME
	15.	WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address
1	(Yes	no. or unknown) (If yes, give war or doise of service) 5.79-60-1981 FREDERICK M. DAVENPORT-SON-1115-5"AVE,
		18. CAUSE OF DEATH [Enter only one cause per line for (a): 19. and (c):] PART I. DEATH WAS CAUSED BY: ONSET AND DEATH ONSET AND DEATH
		4500 DUE TO DUE TO
		Conditions, if ony, which) (b) Generalezed aclerent elerons 20 years
		gave rise to immediate cause (a), stating the under. DUE TO and thrombs plebates 2-3 morety
3	CATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? YES \(\) NO \(\)
	CERTIFI	20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)
	MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour o. m. 19 While at wark
) Fu	u	21. I certify that I attended the deceased from 1960, 19, ta 8-3-, 1967, that I last saw the deceased
		alive an 7-28, and that death accurred at 13:10 9 M, from the causes and on the date stated above. ADDRESS (Street, city of longs, state) DATE SIGNED
	8	ACTUAL SIGNATURE SECURE 2 Decemb M.D. 183 St 3 Mel 8-3-67
1		PHYSICIAN'S JAMES T. BURNSMD Washington De 2006
0/	-	BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State)
M		remation 8-5-1967 Cedar Hill Crematory Suitland Ma FUNERAL DIRECTOR'S SIGNATURE ADDRESS Washing to DC 240. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE
12/	3	Joseph Thurlers Sons, Inc. 5130 - Here are Med. DATE AUG 8 1967 Pleases Judge
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1	1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND	
<u> -</u>	(M)	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 11159	
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uire g ph	pand	conditions, If any, which gave rise to Immediate (b)	
PHYSICIAN: The law requires that the hospital or attending physician, this certificate has been signed by	ior to	cause (a), stating the DUE TO then body breshdon - truck buttook it with	
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YSIC hos	ach ept.		tate)
# # # #	de de l	Hour a.m. While Not While factory, street, office bldg., etc.)	(atc)
DING bd b	d be St	21. I certify that (I) (this hospital) attended the deceased from 2 /2 1, 19 5 1, 19 5 1, that (I) (w	(a) last
TEN taine	hou th	saw the deceased alive on 1947 1967, and that death occurred at 1/3 M, from the causes and on the date stated	
R AI e re	3 s wit	22a. SIGNATURE 1 22b. DATE SIGNED	
ay b	filec	M.D. PHYS. DIRECTOR STAFF M.D. PHYS. DIRECTOR PHYS. DIRECTOR DIRECTOR PHYS. DIRECTOR DIRECTO	
D HOSPITAL OR ATTENDING Page 4 may be retained by FUNERAL DIRECTOR: After	director, page 3 should be detached for use as the b should be filed with the State Dept. of Health prior to b	22c. PHYSICIAN'S NAME (Type) (h B) H WOLOHON 831 UNENSITY BIVE. E. S. (. Spring,	Md.
Page Page	direc	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (Ste	ate)
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1		MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 2129	01
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		D. USUAL OCCUPATION (Give kind of work done lob. KIND OF BUSINESS OR location like the location of the location of the location l	ZEN OF WHAT
INER: This certificate shauld be executed within 24 haurs e certificate, writing the ward "pending" in pencil in Item I should be farwarded to the Chief Medical Examiner's Office files. 3 should be used as a burial-transit permit. File pages land 2 int, prior to burial, cremation, or remaval, and in any event		FATHER'S NAME Richard Denchfield, Kathleen Carlson	U.S.
executed with anding" in permit Exar File emaval, and emaval, and		. WAS DECEASED EVER IN U.S. ARMED FORCES? Id. SOCIAL SECURITY NO. If yes give war ar dates of service) no	e)
be execute "pending" hief Medical ansit permit. or remaval,		18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction	INTERVAL SETWEEN ONSET AND DEATH 24 hours
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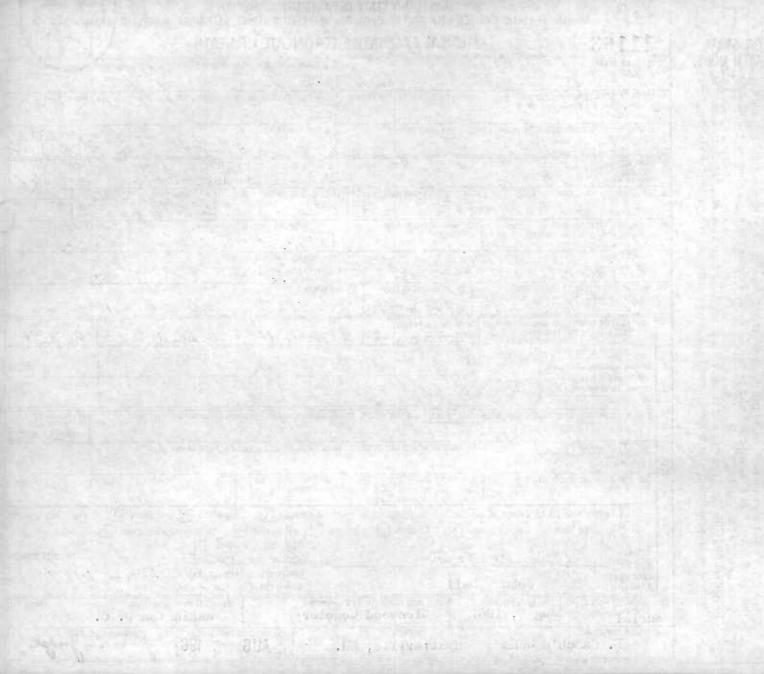
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11162 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) b. county Montgomery o. COUNTY o. STATE b. CITY OR TOWN (If outside carparate limits, MARYLAND hours after c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carporote limits, write RURAL and give nearest town) write RURAL and give nearest tawn The law requires that the death certificate be executed within 24 haurs Koma d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? Within 72 YES NO T 3. NAME OF Middle DATE First Day Year carron DECEASED 196 (Type or print) DEATH Augus heoma S. SEX 6. COLOR OR RACE B. DATE OF BIRTH AGE (in years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIEO NEVER MARRIED regione lost birthdoy) Months Doys Hours WIDOWED OIVORCED 10b. KIND OF BUSINESS OR 10o. USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Store, or foreign country) and in a physician a during most of working life, even if retired) COUNTRY? INDUSTRY GOUT 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME crematian, ar remaval, MATY Downs erry 1S. WAS DECEASED EVER IN U.S. ARMEO FORCES? INFORMAN) (Yes, no, or unknown) (If yes, give wor or dotes of service Maconey Kecords Washington DALAG JNTPRVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b) signed by the burial-transit p PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse lost OS WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES 🔀 NO 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg., etc.) O FUNERAL DIRECTOR: After of work L ot work 21. I certify that (1) (this hospital) attended the deceased from 1967, that (1) () ast director, page 3 shauld shauld be filed with the 7, and that death accurred of 250M, from auses and on the date stated above. saw the deceosed alive on. 22q. SIGNATURE 22b DATE SIGNED ATTENDING M.D. PHYS. PHYS. 22d., ADDRESS 22c. PHYSICIAN'S 909 Pershing Dr NAME (Type) Harry N. Carlton 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION 23b. DATE THEREOF (County) REMOVAL (Specify) Fort Lincoln Cemetery Prince Georges Co. Burial 2So. REC'D BY REGISTRAR Avenue VR A15 (4) 25M 1/67

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// 1 //	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 212	201,
FOR STATE	11163 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	11164
HEALTH DEPT.	1. PLACE OF DEATH a. COUNTY MARYLAND MARYLAND 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence of STATE of COUNTY) MARYLAND MARYLAND MARYLAND	muru
r death. If Say delay is ve Pages 1, 2, and 3 to g with form PM3. Page the State Department of in 72 haurs after death	b. CITY OR JOWN (If outside corporate limits, write RURAL and give write, RURAL and give hearest town) C. LENGTH OF STAY IN 1b C. CITY OR JOWN (If outside corporate limits, write RURAL and give Berling STAY IN 1b C. CITY OR JOWN (If outside corporate limits, write RURAL and give write, RURAL and give street address) d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS	e nearest toy/n) / / / / / e. IS RESIDENCE
s 1, s 1, orm 20	Suburban Hospitals 4400 East West Highwa	YES NO A
within 24 haurs after death. If pencil in Item 18. Give Pages 1, xaminer's Office along with form ile pages land 2 within 72 haurs and in any event within 72 haurs	3. NAME OF DECEASED (Type or print) S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED R. DATE OF BIRTH 19. AGE (In years) IF UNDER 1	Day Year H 1967 YEAR LIFTUNDER 24 HRS.
	male white WIDOWED DIVORCED 11/13/30 36 st birthdown Months	Days Haurs Min.
within 24 haurs a pencil in Item 18. caminer's Office alle pages 1 and 2.	during most of working life, even if retired) INDUSTRY Wash. C.	UNTRY?
J within 24 n pencil in Examiner's File pages and in any	13. FATHER'S HAME 14. MOTHER'S MAIDEN, NAME	7
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d be execute d "pending" Chief Medica rransit permit , ar remaval	18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thymomathe option of the country of the cou	INTERVAL BETWEEN ONSET AND DEATH
CAL EXAMINER: This certificate shauld be executed within 24 haurs execute the certificate, writing the ward "pending" in pencil in Item 1 ar. Page 4 should be forwarded to the Chief Medical Examiner's Office d for your files. TOR: Page 3 shauld be used as a burial-transit permit. File pages 1 and 2 and 3 a	Conditions, if any, which gave rise ta immediate cause (a), stating the underlying cause DUE TO DUE TO DUE TO	
is certifica ie, writing forwarde e used as a burial, c	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	19. WAS AUTOPSY PERFORMED? YES X NO
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AL EXAMINER: execute the cert r. Page 4 should far yaur files. FOR: Page 3 shaunated agent, pr	p.m. 17 atwark — atwark —	unty) (State)
ector. Pa ined for RECTOR: Besignated	21. I certify that I took charge of the remains described above, held on Autopsy , Inspection , Inquiry , death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner	ond in my opinion]
necessary, please execute the certificate, the funeral director. Page 4 should be for 5 may be retained far yaur files. TO FUNERAL DIRECTOR: Page 3 shauld be the Health or its designated agent, prior ta	ACTUAL SIGNATURE SIGNATURE EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county)	22. DATE SIGNED
TO DE neces the f 5 mg	23a. BURIAL, (REMATION, Burial (Specify) Aug 8, 1967 23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery Washington D. C	
VR A15ME (5) 6M 1/66	24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. ADDRESS ADDRESS ADDRESS DATE AUG 8 1967 ADDRESS DATE AUG 8 1967	es Judge



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11164

CERTIFICATE OF DEATH

11165

death uneral and 2	1. PLACE OF DEATH a COUNTY Montgomery Marylan	USUAL RESIDENCE (Where deceased lived, if institution: Residence befare admission) O. STATE b. COUNTY
24 haurs after ad in by the furpers. Progres 172 hours offer	b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn)
o o	Kensington	Kensington 151
in 24 ho filled in papers.	d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street oddress)	d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
filled pape pape hin 7.	Kensington Gardens Nursing Home	4219 McCain Court YES NO X
campletely f ave carbon y event, with	3. NAME OF DECEASED (Type or print) First FRANZICA Middle	DOSS 4. DATE Month Day Year OF DEATH August 18,1967
and camp	S. SEX Female 6. COLOR OR RACE White 7. MARRIED NEVER MARRIED DIVORCED	8. DATE OF BIRTH Nov.14,1878 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Manths Doys Haurs Min.
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ding t. I	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, occupations) (If yes give wor or dotes of service)	17. INFORMANT Address
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quires thous physician. signed by burial-trar burial, cre	Conditions, if any, which gave) (b) Coses Coses	Dastoria selevara 30 75
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te law restanding as been as the priar to	lost. (c)	The state of the s
E 0 4 9 4 1	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED	TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES NO 3
for file	OR CONTRIBUTING CAUSE OF DEATH	RED. (Enter nature of injury in Part I ar Part II af item 18.)
of the se	2Dc. TIME OF INJURY Manth, Day, Year Hour a.m. P.m. A Photographic Color of While at work at	PLACE OF INJURY (Home, farm, foctory, street, office bldg., etc.) 2Df. (City or town) (County) (State)
ATTENDING stained by 1 CTOR: After shauld be a ith the Stat	21. I certify that (1) (this haspital) aftended the deceased fra	n, 19_67, to, 1967, that (I) (we) last that death occurred at, M, fram causes and an the date stated above.
× 3 × ×	22a. SIGNATURE	M.D. ATTENDING MED. STAFF 22b. DATE SGNED MED. PHYS. 22b. DATE SGNED MED. PHYS. 12c. 12c. 12c. 12c. 12c. 12c. 12c. 12c
TAL AL AL Pag Pag e fij	22c. PHYSICIAN'S NAME (Type) Franklin H. Kreuzburg	22d. ADDRESS 7852 - 16th. St., N.W., Washington, D.C.
O HOSPI Page 4 m O FUNER director,	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETER	OR CREMATORY 23d. LOCATION (City or Town) (County) (State)
5 5 5 W	Cremation 8/19/67 Cedar Hill	
VR A15 (4)	ys the wheeler Funeral Home-1331 Rock	
25M 1/67	Rockville.Md.	DAAUG 2 1 1967 yellarles Judge

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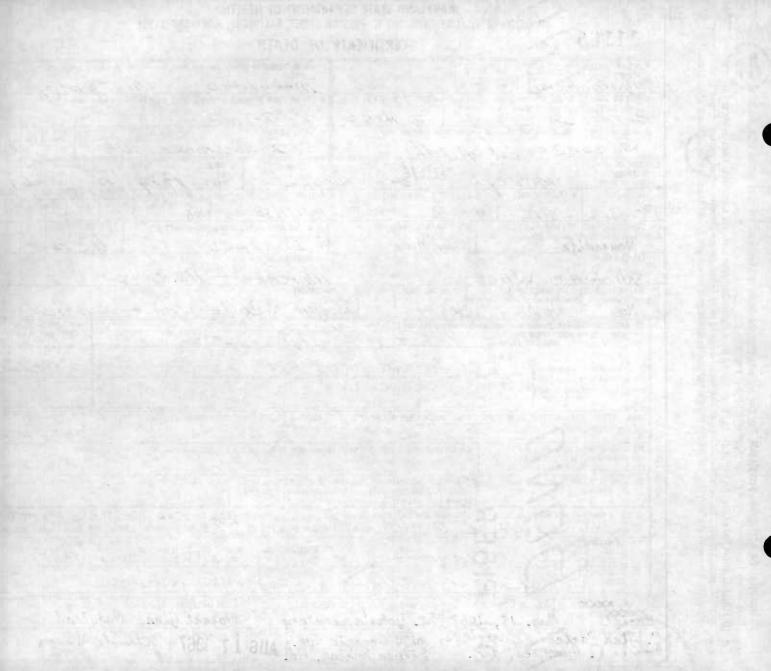
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11165

CERTIFICATE OF DEATH

11166

N . N .:	CENTIFICATE OF DEATH	
and and death	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Resid	ence before odmission)
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s after the toges rs after	b. CITY OR TOWN (If autside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and g	five nearest town)
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ate b ician lease and i	during most of working life, even if retired) ADDUSTRY Own Home IRELAND	COUNTRY?
ertificate b physician ien please aval, and i	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	
ave ave	Maria Maria	
an The	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address	
at indi	(Yes, no, or unknown) (If yes give wor or dates of service),	
he death ce attending p permit. The ian, or remo	No NONe yes NosepH. K. DoyLE - SON -	SAME
t the a the sit per natia	1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)	INTERVAL BETWEEN
nsit #	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) NTRUCTON OBS TRUCTON	ONSET AND DEATH
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equires that the death certific physician. signed by the attending phys burial-transit permit. Then p burial, crematian, or remaval,	Conditions if any which have	2 X Variet
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OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs aft are retained by the haspital ar attending physician. INECTOR: After this certificate has been signed by the attending physician and campletely filled in by the e 3 shauld be detached far use as the burial-transit permit. Then please remare carban pagers. Pages ad with the State Dept. af Health priar ta burial, crematian, or remaval, and in any event, within 72 hours of	last. (c)	
ds as	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY PERFORMED?
IAN: The cal ar att ficate ha far use Health p	20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER MOTIFE MEDICAL EXAMINED) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	YES NO
de de de	20o. ACCIDENT WAS UNDERLYING 2	
日本語 2	© OR CONTRIBUTING □ CAUSE OF DEATH	
G PHYSIC the haspit this certificated detached e Dept. af		Caunty) (Stote)
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D t t b e	p.m. 19 at work at wark	CAL TO THE PARTY OF THE
by be Stat	21. I certify that (I) (this haspital) attended the deceased fram JAN , 1936 to AUC 12, 19	9 42, that (1) (we) tos
R: Red	sow the deceased glive an AGG 12 19 (2), and that death occurred of 2 19 M, from causes and on	the date stated obove
45 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	22b.	DATE SIGNED
OR ATTENDING PHYSICIAL be retained by the haspital DIRECTOR: After this certifice je 3 should be detached fai ed with the State Dept. af He	M.D. ATTENDING DIRECTOR STAFF PHYS.	0/12/17
o a a a a a a a a a a a a a a a a a a a	22c PHYSICIAN'S 22d. ADDRESS	
TA AL	NAME (Type) DR LEO I DUNOVAN 8218 WISCONSINANC	
Page 4 may be retained by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been director, page 3 shauld be detached for use as the shauld be filed with the State Dept. af Health priar ta		75 75 75 75
HO Be Be Included Inc	23a. BURIAL, CONTACTION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town)	(County) (Stote)
5 0 0 p v	Burial "Mug. 13. 146/12t. John & Cemetery Jorest Glen, "a	ryland
71 0	Ca. FUNTED DIRECTOR TEA Colon Cartes 84 34 5 Georgia Ave. 250. RECD BY REGISTRAR 254 DECISTRAR ALIG 17 1967 Colonia	SIGNATURE
VR A15 (4) 25M 1/67	Warner & Pumphrey Inc. Silver Spring Md AUG 17 1961 Miller	10



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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH RAFFIL and 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH a. COUNTY b. COUNTY a. STATE MONTGOMERY MARYLAND DISTRICT OF COLUMBIA b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) write RURAL and give nearest tawn) BETHESDA 29 DAYS WASHINGTON requires that the death certificate be executed within 24 haur e. IS RESIDENC d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS ON A FARM? YES NO TY 2910 R. ST. NAVAL HOSPITAL Middle 3. NAME OF 4. DATE Day First Year DECEASED (Type or print) DOROTHY CONNER DUGGER DEATH AUGUST S. SEX B. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthday) Manths WIDOWED DIVORCED 15 SEPT 1890 FEMALE CAUC 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) during mast af warking life, even if retired) **INDUSTRY** COUNTRY? HOMEMAKER

13. FATHER'S NAME II.S NONE TNDTANA

14. MOTHER'S MAIDEN NAME CHARLES H. CONNER DOROTHY CONNOR Nee-Atterbury 16. SOCIAL SECURITY NO. 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknown) (If yes give war or dates of service) 579 60 0274 JOHN H. DUGGER. 2722 OLIVE ST. N.W. WDC 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (0) LYMPHOSARCOMA, LYMPHOCYTIC TYPE, METASTATIC TO KIDNEY AND POSSIBLY TO BRAIN Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES TO NO far 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, (City or town) (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (County) Haur a.m. factory, street, affice bldg., etc.) Not While at wark at work 21. I certify that (I) (this haspital) attended the deceased fram 11 JULY , 19 67, to AUGUST , 19 67, that (I) (we) last saw the deceased alive an 9 AUGUST 19 67, and that death accurred at 3:30AM, fram causes and an the date stated above. , 19 67, that (I) (we) last 22b. DATE SIGNED 22a. SIGNATURE ATTENDING PHYS. STAFF ZWD. DIRECTOR PHYS. 9 AUGUST 1967 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) L. W. RAYMOND NAVAL HOSPITAL, BETHESDA. directar, should b 23a. BURIAL, CREMATION, 23b. DATE THEREOF (State) (County) OAK HILL CEMETERY 2Sb. REGISTRAR'S SIGNATURE Melantes VR A15 (4) DEVOL FUNERAL HOME, 2222 WISCONSIN AVE, NW, WDCbate AUG 1 1 1967 20 M 1/66

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hays after death. Page 4 may be retained by the haspital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

ESTON STREET, BALTIMORE, MARYLAND 21201 11169

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CERTIFICATE OF DEATH

1.	PLACE OF DEATH		2. USUAL RESIDENCE (W	here deceased lived, if	institution: Residence l	pefare admission)
	a. COUNTY May to any	MARYLAND	a. STATE Many	land t	o. COUNTY	/
	b. CITY OR TOWN (If applied carparate limits.	LENGTH OF STAY IN 1b	c. CITY OR TOWN (If but	ide corporate limits w	MONT 90M	
	write RURAL and give negrest tawn)		1	^	HE KUKAL OHO-GIVE HE	orest rown)
	Takona Park	26 days	lakoma	Park		151
	d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give	street address)	d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?
1	Vashington Sonitarium and		8322 Roa	noke Ave	enue	YES NO
3.	NAME OF First DECEASED	Middle	Last	4. DATE	Manth	Day Year
	(Type or print) Perry AL	exander	Due	OF DEATH	ugust	8 19 67
S.	SEX 6. COLOR OR RACE 7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In ye		
	Male White WIDOWED	DIVORCED 🔲	3-12-86	last birthe	yrs. Months Do	ays Haurs Min.
100	. USUAL OCCUPATION (Give kind of wark done ing most of working life, even if retired) INDUS	OF BUSINESS OR	11. BIRTHPLACE (County &	State, ar fareign country) 12. CITIZE COUNT	N OF WHAT
UUI	Retired	IKI	Virgin	in	COUNT	America.
13	FATHER'S NAME		14. MOTHER'S MAIDEN NA		1000000	7.77.67
	ALexander Due		Helen	Ho/mes		
		AL SECURITY NO. 17. I	INFORMANT	,	Address	
(1)	s, na, or unknown) (If yes give war ar dotes of service)	8-05-2928	Hacrital C	hart		
=	18. CAUSE OF DEATH (Enter only one cause per line for (a).		170301141	1411		INTERVAL BETWEEN
	PART I. DEATH WAS CAUSED BY:		1-H- 1) ++	111	ONSET AND DEATH
	177 X IMMEDIATE CAUSE (a)	AVEIROMA	0/ /ne 1	rosporp	YIdnb	> (in or this
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	Conditions, if any, which gave (b) (b)	10 Tes/0845.				months.
	stating the underlying couse DUE TO	x / / L				il. Va
	last. (c)	1) phy dration				Weers
2	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO D	EATH BUT NOT RELATED TO	THE TERMINAL DISEASE COND	ITION GIVEN IN PART I	(a)	19. WAS AUTOPSY
150	THE RESERVE OF THE PARTY OF THE					PERFORMED?
FIG	20a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRI	BE HOW INJURY OCCURRED.	(Enter nature of injury in Pr	art I or Part II of item	18)	123 113 12
MEDICAL CERTIFICATION	OR CONTRIBUTING CAUSE OF DEATH	and the second s	Taring at milety in the		,	
AL ((IF EITHER, NOTIFY MEDICAL EXAMINER)	V OCCUPATO I OO. DIA	CE OF INJURY (Home, farm,	20f. (City or to	own) (Caunty	161-4-1
ă	20c. TIME OF INJURY Manth, Day, Year 20d. INJUR Hour o.m. While		ory, street, affice bldg., etc.)	20f. (City or to	wii) (cduii)	y) (State)
2	p.m. 19 at work					
	21. I certify that (I) (this hospital) attended	the deceased from	Jebruery , 19		us. 8, 1967	, that (I) (we) la
1	saw the deceased alive an Aug. 7	19_67, and that	t death accurred at_	4P M, fram ca	uses and an the	date stated abov
	220. SIGNATURE de la Como am	, MO	ATTENDING A	AED. STAFF	22b. DATE	SIONED
	Le dr. R. Sandstra	n/ . NO M.I	D. PHYS.	MED. STAFF DIRECTOR PHYS.	. 0 8,	18/67
	22c PHYSICIAN'S	./	22d. ADDRESS	((A /	de 10
	NAME (Type) HUGO G. GRAZI)	FW7 1 1935 -	10101	Geor 61	4 AUE	00. 170
23	BURIAL, CREMATION, 23b. DATE THEREOF 2	23c. NAMÉ OF CEMETERY OR	CREMATORY	23d. LOCATION (City	y ar Town) (Ca	ounty) (Stote)
	REMOVAL (Specify) 8/11/67					~
	EUNERAL DIRECTOR	Ft. Lincol	n emetery	Prince BY REGISTRAR 12	Sh_REGISTRANK NIGN	County Me
1	Charles Co.	1901 14th CT		ALIG 10 19	67 July	res Judge
1	Me Alot Wesses (W C	17/1/14401	1/1/ . DATE	1100 - 0	1/	0

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11169 MEDICAL EXAMINER'S CERTIFICATE OF FOR STATE HEALTH-DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o COLINTY b. COUNTY MARYLAND b. CITY OR TOWN (If outside carporate limits write RURAL and give marest town) c. LENGTH OF STAY IN 1b corporate limits, write RURAL and give nearest town) 9 after parti not in hospital, give street address) d. STREET e. IS RESIDENCE form hours ON A FARM? Stote YFS death. NAME OF Middle DATE Lost Doy Year DECEASED OF within (Type or print DEATH S. SEX AGE UNDER 24 HR NEVER MARRIED Months rhdoy) Dovs Hours WIDOWED event 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT (State or foreign country) during most of working life, even if retired)

Nath Salismana COUNTRY? -Onv = Examiner's 13. FATHER'S NAME . = File puo INFORMANI 17. removal, INTERVAL BETWEEN ONSET AND DEATH CAUSE OF DEATH (Enter only one couse par line burial-tronsit PART I. DEATH WAS CAUSED BY 10 IMMEDIATE CAUSE (o' Word cremation, certificate should DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse forwarded lost. buriol, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPS'
PERFORMED? NO certificate, 0 pe 20o. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING ☐ CAUSE OF DEATH. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury Port agent, prior should CRARRA 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED OF INJURY (Home, form, (City or town County (Stote Not While foctory street office blde, etc.) DIRECTOR: Page of work pleose execute designated 21. I certify that I took charge of the remains described above, held an Autopsy for Inspection X Inquiry X and in my opinion the funerol director. death resulted from: Notural couses Suicide Hamicide Undetermined manner retoined CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE FUNERAL O DEPUTY pe Heolth or may NAME (Type) 23c. NAME OF CEMPTERY OR CREMATORY 23o. BURIAL, CREMATION, 23b. DATE THEREOF LOCATION (City or Town) (County) (Stote) 0 REMOVAL (Specify) 26. REGISTRAR'S SIGNATURE DIRECTO VR A15ME (5) Milianles 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

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_ 1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
. =2:	11170 CERTIFICATE OF DEATH
e funeral 1 and 2 er ceath.	1. PLACE OF DEATH a. COUNTY A. COUNTY A. STATE B. COUNTY A. STATE B. COUNTY A. STATE B. COUNTY B. COUNTY A. STATE B. COUNTY B.
rs after by the fr Pages 1 urs after	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
hours d in by rs. Pa	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE
fille pape in 77.	1900 LYTTENSVILLE FOAD 1900 KYTTONSVILLE BYES NO NA FARNI
= 0-	3. NAME OF First Middle Last 4. DATE Month Day Year OF DECEASED (Type or print) LOUIS N. EISEN DEATH August 20 1967
comple care	5. SEX 6. CQLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HR
execur T and T emov	MALE WHITE WIDOWED DIVORCED 7-Oct-1889 1st birthday) Months Days Hours Min
icate be e physician n please in val, and in	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR JUNE 11. BIRTHPLACE (County & State, or foreign country) 11c. CITIZEN OF WHAT COUNTRY? COUNTRY?
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certifica Iding ph Then removal	SAMUEL KISEN TOBEY KLEIN
e death certific the attending p t permit. Then ation, or remov	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or Junkown) (If yes give war or dates of service)
es that th hysician. signed by urial-transi urial, crem	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARCINOMA OF PANCREAS E METASTASES DUE TO Conditions, If any, which and continued are represented by the continued by the con
requirending postering peen the peen or to be	cause (a), stating the DUE TO
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS' PERFORMED? YES NO NO NO NO NO NO NO N
PHYSICIAN: The the hospital or this certificate detached for us the Dept. of Health	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
PHYY the this deta deta	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED At While Documents of the street, office bldg., etc.) State County County
ATTENDI retained ECTOR: A 3 should with the	21. I certify that (I) (this hespital) attended the deceased from ACCIL 27, 1954, to Avg. 20, 1967, that (I) (we) la saw the deceased alive on Avg. 19 1967, and that death occurred at 22AM, from the causes and on the date stated above 22a. SIGNATURE 22a. SIGNATURE AUG. 20, 1967
	22c. PHYSICIAN'S NAME (Type) ISRAEL KESSLER, M.D. PHYS. DIRECTOR PHYS. 1409, 20, 196 22d. ADDRESS S80-16 = St., N.W., WASh., D.C.
Page 4 mgr Page 4 mgr CO FUNERAL director, p should be	23a BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d JOCATION (City town or county) (State) REMOVAL (Specify) 8/21/1967 NAT'L MEM. TARK FALLS CHURCH
VR A15 (4)	24. FUNERAL DIRECTOR GOLDBerg FONDALL HOME 427-9 S-Kee DATA UG 2 2 1967 Charles Junger
15M 4-64	

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cather papers. Rages 1 and 2 ent, within 72 hours after death.

death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hosping 8 4 may be retained by the haspital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and camprefely filled in director, page 3 shauld be detached for use as the burial-transit permit. Then please remaye cappen shauld be filed with the State Dept. at Health priar ta burial, crematian, ar remayal, and in any event, within 72 h

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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		o. COUNTY					o. STATE	NCE (Where	deceosed live			ce before	odmissio	on)
		Montgomery			MARYLAND 0. STATE			Maryland b. COUNTY						
		b. CITY OR TOWN (If outside corporate limits.		c. LENGTH OF STAY	IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL		AL ond give	e nearest	town) /				
		write RURAL and give nearest town) Bethesda (rural)		24 days		Rockville				15.1				
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)			1.536	d. STREET ADDRES					e. IS RESIDENCE			
6	-9	Naval Hospital				11125 Stephalee Lane ON A FARM					NO S			
		NAME OF		irst	Middle	- 11	Lost		ATE	Mont	h	Doy	Yeo	
		(Type or print)	Hile	de l	Saunders		ESPE		OF DEATH	Augu	et	24	19	67
4	S.	SEX	6. COLOR OR RACE		NEVER MARRIE	ED 🗍	8. DATE OF BIRTH		10 400	/1-	IF UNDER	1 YEAR	IF UNDER	24 HRS.
	F	remale	Cauc	WIDOWED	DIVORC	ED 🔲	Jan. 19,	1903	64	birthdoy) yrs.	Months	Doys	Hours	Min.
	10o	. USUAL OCCUPATION	(Give kind of work done	10b.	KIND OF BUSINESS OR		11. BIRTHPLACE (Co	ounty & Stote	e, or foreign co			TIZEN OF	WHAT	
	duri	during most of working life, even it retired) INDUSTRY NA			INDUSTR'N/A		Madiso	n, Do	rchest	ter Co	. (0	UNTRY?	Ţ	JSA
	13.	13. FATHER'S NAME			11/3/3	14. MOTHER'S MAIDEN NAME Md.								
		Whitely Saunders					Julia	Craig						
	IS.	WAS DECEASED EVE	R IN U.S. ARMED FORCES?	16	SOCIAL SECURITY NO.	17. 1	NFORMANT lee			Addre	Rockv	ille	. Md	1.
	(70	NO NO	(If yes give wor or dotes	of service)			DM Carl F							
			EATH (Enter only one co		or (o), (b), ond (c).)						,		EVAL BET	
		PART I. DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE	(a) Card	cinoma Bres	ist						ONSE	T AND D	EATH
		170	X DUE			7304								
		Conditions, if ony, which gove) (h)												
		rise to immediat		10										
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	z	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED?												
2	MEDICAL CERTIFICATION											YES		NO X
	TIFIC	20o. ACCIDENT WAS		20b. I	DESCRIBE HOW INJURY	OCCURRED.	(Enter noture of inju	ry in Port I	or Port II of	item 18.)				
	CER	(IF EITHER, NOTIFY	CAUSE OF DEATH MEDICAL EXAMINER)	12 6										
	OICAL		JRY Month, Doy, Yeor		INJURY OCCURRED		E OF INJURY (Home		20f. (City	or town)	(Cor	unty)	(Stote)
	ME	Hour o.r	10	Whi of wo	le Not While ork of work	toct	ory, street, office bldg	., etc.)						
		21. I certif	fy that (1)x(this has			from	31 July	_, 19_6	7, to 21	Aug.		67 the	t (4) (v	we) last
			eceased alive an_2		19.67	and that	death accurred	d at105	OAM, fran	n causes o	and an th	ne date	stated	abave.
		220 SIGNATURE	O	11	à		ATTENDING _	MED.		CTAFF	22b. D/	TE SIGNED		1967
			us E.	file	ws	M.D). PHYS. L	DIREC	TOR 🗆	PHYS.	24	Aug	ust	1901
		22c. HYSICIAN'S 22d. ADDRESS Naval Hospital, Bethesda, Md.												
/		//	James L		s, M. D.			ноѕр	itai,	betne	saa,	Ma.		
	230	DURIAL, CREMATIC	ON, 23b. DATE TH		23c. NAME OF CEA	METERY OR	CREMATORY	. 23	Bd. LOCATION	(City or Tow	vn)	(County)	(S)	tote)
		Burial			Arlingto	on Na	tional		Arling	ton,	Virgi	nia		
	24	I. FUNERAL DIRECTO	Joseph Gar	vler &	Sons Fune	ral H	ome 2So.	REC'D BY R	EGISTRAR	2Sb. REC	USTRAR'S	GNATURE	de	
		5130 Wi	sconsin Ave	N.	W., Washin	gton,	D.C. DATE	106 4	8 106	1		1	0	

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11174 11173 CERTIFICATE OF DEATH . PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) o. COUNTY o. STATE b. COUNTY MARYLAND The law requires that the death certificate be executed within 24 haurs after (Il outside corporote limits, d give nearest tawn) c. LENGTH OF STAY IN 1b write RURA! d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? filled .9 3. NAME OF First Middle Lost DATE Year campletely 13 DECEASED OF DEATH (Type or print) IF LINDER 24 HRS DATE OF BIRTH AGE (In years IF UNDER 1 YEAR S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED remave Months Doys Hours WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done BIRTHPLACE (County & Stote, or foreign country) physician a nen please during most of working life, even if retired) COUNTRY? INDUSTRY 13. FATHER'S NAME ar remava 17. INFORMANT 15. WAS DECEASED EVER IN US. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service) crematian, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), /(b), and (c)/ ONSET AND DEATH burial-transit PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) þ DUE TO signed ! burial, Conditions, if ony, which gove (b) rise to immediate couse (o), DUE TO stoting the underlying couse has been the Health priar ta PART II. OTHER SIGNAPHEANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) WAS AUTOPSY PERFORMED? use CERTIFICATION YES NO O FUNERAL DIRECTOR: After this certificate OR ATTENDING PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) Hour o.m. foctory, street, office blda, etc.) Not While 19 ot work 21. I certify that (1) (this hospital) altended the deceased fram. 19 5, 19__, that (1) (we) las and that death occurred at 95% M, from causes and on the date stoted obove saw the deceased alive on_ 220. SIGNATURE 22b. DATE SIGNED **OIRECTOR** PHYS. PHYS 22d. ADDRESS 22c. PHYSICIAN'S TO HOSPITAL NAME (Type) directar, shauld I 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) 20 250. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE VR A15 (4)

TOWN OF STREET

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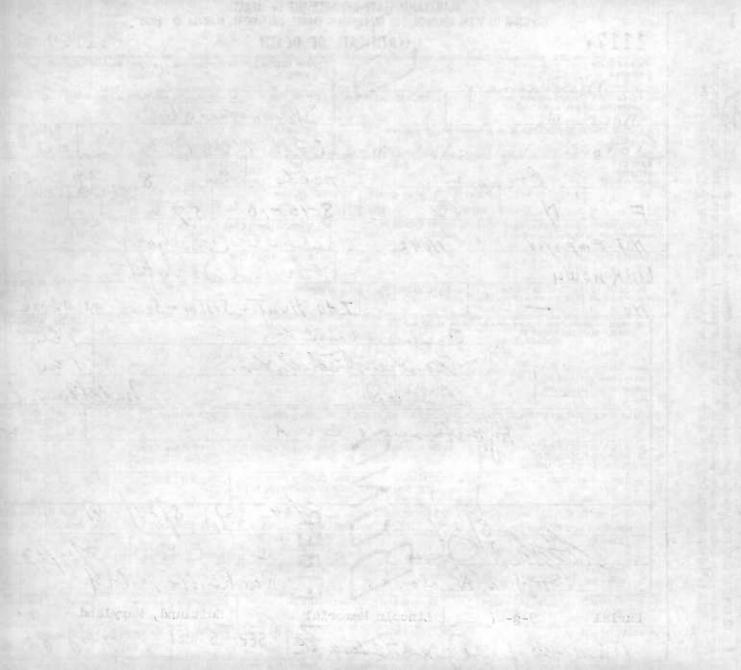
9 1	Sa. 7	Item 18 Film 393 MARYLAND STATE DEPARTMENT OF HEALTH 10-5-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
FOR STATE	/	11175 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
delay is and 3 to and 3 to AN3. Page	T)	1. PLACE OF DEATH a. COUNTY MONT.gomery b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b C. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town)
es 1, 2, farm P farm P	171	write RURAL and give nearest town) Takoma Park d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) Washington Sanitarium and Hospital LOL Elm Avenue
24 haurs after death. If of in Item 18. Give Pages 1, r's Office alang with farm es I and 2 with the Nate De		3. NAME OF DECEASED (Type or print) Richard Mark Fann DEATH August 18 19 67 S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED X 8. DATE OF BIRTH 9. AGE (In years lift UNDER 1 YEAR IF UNDER 2 4 HRS. lost birthday) Months Days Hours Min.
hin 24 haurs on in them 18 niner's Office on pages land 2 were doubt	drer dedin	Male White WIDOWED DIVORCED 2-26-60 7 yrs.
id with in period in perio	72 nours	13. FATHER'S NAME George M. Fann 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no Patient's chart
ficate shauling the warded to the	any event	18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: Multiple extreme injuries with ONSET AND DEATH Canditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) INTERVAL BETWEEN ONSET AND DEATH INTERVAL BETWEEN ONSET AND DEATH
This ficate, be found be	leillovai,	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES NO 200. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CONTRIBUTING CONTRIBUTING CAUSE OF DEATH. 201. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CONTRIBUTING CAUSE OF DEATH.
L EXAMIN cecute the Page 4 sh far yaur fil	cremandin,	20c. TIME OF INJURY Manth. Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City town) Runcing Mile at wark at wark 21. I certify that I taak charge of the remains described above, held an Autapsy (Inspection), Inspection (State) (
JTY ry, peral eral be re	pridr Ta	death resulted fram: Natural causes , Accident , Suicide , Hamicide , Undétermined manner ACTUAL SIGNATURE
10 DEPU 10 DEP	OW	23a. BURIAL CREMATION, REMOVAL (Specify) 24. FUNERAL DIRECTOR 25. DATE THEREOF 23c. NAME OF CEMETER OF REMATORY ADDRESS ADDRESS DATE AUG 2 2 1967 ADDRESS DATE AUG 2 2 1967 AUGUSTAN SIGNALURE 25. REC'DEV REGISTRAR'S SIGNALURE 25. AUGUSTAN SIGNALURE 25. AUGUST
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11177 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE h COLINTAL npletely filled in by the fune of arbon papers. Poges 1 of ent within 72 hours after d MARYLAND b. CITY OR TOWN (If outside corporate/limits white RURAL day give neorest town) LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS YES NO V completely fi 3. NAME OF DATE Year. DECEASED (Type or print) DEATH 9. AGE (In years hirthdoy) S. SEX 6. COLOR OR RACE X IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED DATE OF BIRTH Months Hours in ony WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 10o. USUAL OCCUPATION (Give kind of work done) during most of working he eyen if retired) 12. CITIZEN OF WHAT 11. BJRTHPLACE (County & Stote, or foreign country) INDUSTRY COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME offending parent. The IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) Uremia q DUE TO Hydronephrosis & pyelonephritis, acute & chronic Conditions, if ony, which gove (b) rise to immediate couse (a). DUE TO stoting the underlying couse the hospitol or ottending as the this certificate has been Neurogenic bladder due to meningomyelocele 19. WAS AUTOPSY PERFORMED? YES NO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) USe Health p NO F 0 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) detoched for the Dept. of F OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept. 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) foctory, street, office bldg., etc.) Not While of work TO FUNERAL DIRECTOR: After TO HOSPITAL OR ATTENDIN Poge 4 moy be retained by 196 / that (1) (we) las 21. I certify that (I) (this hospital) attempted the deceased fram. 27, and that death accurred at 10 AM, fram causes and an the date stated above saw the deceased alive on 220. SIGNATURE ATTENDING PHYS. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S Wis. Ave. M**W* Bethesda NAME (Type) J. Tehan Timothy director, should b 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, 23d. LOCATION (City or Town) (County) (Stote) Cremation Fort Lincoln Bladensburg 25b. REGISTPAR'S SIGNATURE Ernest C Gartner Gartnersburg Md. 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR

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_ 1	1		DIVISION OF VE	MARYLAND STAT TAL RECORDS, 301 W.			LTH RE, MARYLAND 21201		
7		11177				OF DEATH		111	78
funeral 1 ond 2 er deoth		PLACE OF DEATH D. COUNTY		MAR	/LAND 2	e. USUAL RESIDENCE (W o. STATE	here deceosed lived, if institutio b. COUNT		ore odmission)
equires that the death certificate be executed within 24 hours after death physician. signed by the ottending physician and completely filled in by the funeral burial-transit permit. Then please remove corban papers. Pages 1 and 2 burial, cremation, or removal, and in any event, within 72 hours after death		D. CITY OR TOWN (Il outside owite RURAL and give need	corporate limits, rest town)	c. LENGTH OF STAY		Mashus	side corporote limits, write RURA	L ond give neon	est town)
filled in 194 mo	(1. NAME OF HOSPITAL OR INST	TITUTION (If not in ho	L al.	m	6. STREET ADDRESS	esthet n w		e IS RESIDENCE ON A FARM? YES NO
ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 etained by the hospital or ottending physician. CTOR: After this certificate has been signed by the ottending physician and completely filled should be detached for use as the burial-transit permit. Then please remove corbon paper with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72	3.	NAME OF DECEASED (Type or print)	C EORA	Middle	F	elds	4. DATE Month OF OEATH	29	oy Year
d compo	S.	F		OWED D OIVORCE	- 6	2-15-10	9. AGE (In years last birthdoy) 7 yrs.	Months Doys	Hours Min.
ficote be ex ysicion ond pleose rem al, ond in on	dur	USUAL OCCUPATION (Give kind ng most of working life, even if MOT Employ FATHER'S NAME	retired)	10b. KIND OF BUSINESS OR INDUSTRY		South	Stote, or foreign country)	12. CITIZEN COUNTRY	
certificc g physi Then pli moval,	13.	Juk nown			7	4. MOTHER'S MAIDEN N	1 Nright	1	
ne death certifi ottending phys permit. Then p	IS. (Ye	WAS DECEASED EVER IN U.S. AI s, no, or unknown) (If yes give		16. SOCIAL SECURITY NO.	17. INFO	o Hunt-	SisTex- Sam	e as	above
hot the n.y. the o y the o		1B. CAUSE OF DEATH (Ente PART I. DEATH WAS CA IMM	r only one couse per l NUSED BY: MEDIATE CAUSE (o)	ine for (a), (b), and (c).)	an	mt		li C	NSET AND DEATH
The low requires tho ottending physician. hos been signed by se as the burial-tron h prior to buriol, crer		Conditions, if ony, which go	0) (0) —	Vintrie	. Fac	hillater	2	1	h.
The low required of the low red of the low bos been size as the been size the beat the beat of the beat of the beat lower to beat lower to be the beat lower		stoting the underlying coulost.	(c)	ASCU. E	7-		,	under	Frances
IAN: The rol or otter of ficate hos for use of the rolth pr	CERTIFICATION		Hup	JTING TO DEATH BUT NOT RE	+ C	.V.A.			9. WAS AUTOPSY PERFORMED? YES NO
OR ATTENDING PHYSICIAN: be retoined by the hospital or DIRECTOR: After this certificate is 3 should be detached for u ed with the State Dept. of Heol		20o. ACCIDENT WAS UNDERLYI OR CONTRIBUTING ☐ CAUSE ((IF EITHER, NOTIFY MEDICAL EX	OF OEATH () (AMINER)	20b. DESCRIBE HOW INJURY O					
ING PHYSIC by the hospit fter this certi be detached State Dept. of	MEDICAL	20c. TIME OF INJURY Month Hour o.m. p.m.	19	20d. INJURY OCCURREO While Not While ot work	foctory,	OF INJURY (Home, form, , street, office bldg., etc.)	1	(County)	(Stote)
TTENDI Doined b OR: Aff		21. I certify that (saw the deceased 220. SIGNATURE		attended the deceased	fromand that d	eath occurred at	2. M, from/causes	nd an the dell 22b. DATE SIG	that (I) (we) lo ate stoted obov
OR A. DIRECT DIRECT DIRECT See 3 shifted with lifed with life of the control of t		22c. PHYSICIAN'S	Muh!	Jours	M.D.	ATTENDING PHYS. 1	MED. STAFF PHYS.	8/20. DATE SIL	29/67
Page 4 moy be retained by the hospital or ottending TO FUNERAL DIRECTOR: After this certificate hos been director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to	22	NAME (Type)	TEPHEN (N, SONE		1 Roc	Rolle, 23d. LOCATION (City or Tow	M (Coun	ity) (Stote)
TO HOSPII Page 4 m TO FUNER, director, should b		PEMOVAL (Specify) Burial FUNERAL DIRECTOR	9-2-67	Lincoln ADDRESS		ial	Suitland, Ma	aryland	
VR A15 (4) 25M 1/67		Khines	as 3	OK-12 d. 71.8	lines.	NE DATE SET	BY REGISTRAPS 25b. REG	remis (Justin



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7		LACE OF DEATH		V-18-001-001-01			2. USUAL RESIDENCE (Where decea				sion)
	(. COUNTY Montgome	YW7		N	IARYLAND	o. STATE Maryla	nd	b. cou	Montgo	merv	
1	- 1	. CITY OR TOWN (If autside carparate limit	ts.	c. LENGTH OF ST.		c. CITY OR TOWN (If ou	itside carpar				
		olney	d give nearest tawn)		20 day	s	Olney					15-1
	-		AL OR INSTITUTION (If n	at in haspital, g			d. STREET ADDRESS				e. IS RE	SIDENCE
69		Montgor	mery Genera	1 Hospi	tal		Box 73	3		7.23		FARM?
69		NAME OF DECEASED	F	irst	Middle		Last	4. DATE OF	Man		Day	Year
	(Type or print)	Fl	orence	Elizab	eth Fi	nneyfrock	DEATH	Augus		4, 1	
	S. :	SEX	6. COLOR OR RACE	7. MARRIED	NEVER MAR	KILD	B. DATE OF BIRTH		AGE (In years last birthdoy)	Months		ER 24 HRS.
	I	emale	White	WIDOWED	DIVO	RCED 🔲	9/27/90	100	76 yrs.	MOITINS	Days Hour	s Min.
			Give kind of work done		ND OF BUSINESS O	R	11. BIRTHPLACE (County	& State, ar fa	reign country)	12. CITI	IZEN OF WHAT	
		ng mastat warking Housewife	life, even if retired)	IN	DUSTRY HOM	ie	Maryland			COL	JNTRY? USA	
		FATHER'S NAME	•				14. MOTHER'S MAIDEN I				0.00	
		Daubar	. Winne				Mary Bur	าวรัฐส				
	15.		n Hines	16.	OCIAL SECURITY N	0. 17. 1	NFORMANT	2 400	Addre	ess		
		s, no, or unknown)	(If yes give war or dates	of service)	7-34-106		Medical Reco	mda				
		no	FAVIL (F.)			ID I	edical rece	Aus			INTERVAL E	ETIMEEN
		PART I. DEA	EATH (Enter anly ane ca TH WAS CAUSED BY:	use per line far	(a), (b), and (c).)	Maria	- 3.0	Lan	lune		ONSET AND	
		Unno	IMMEDIATE CAUSE		mone	Im	A Caraca	lake				
- 7		Conditions, if any		10	The Var	as.	1	rest	and l	448	WW)
		rise to immediat	a couse (a)	(b)	2000	m ~	Mac 1		- 0		1	
		stating the unde		TO							()	
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	NO	PART II. OTHER SI	GNIFICANT CONDITIONS	CONTRIBUTING T	O DEATH BUT NOT	RELATED TO T	THE TERMINAL DISEASE CO	NDITION GIV	EN IN PART 1(o)		19. WAS AI PERFOI	
2	SATE				L CAN						YES _	NO N
	CERTIFICATION	20g. ACCIDENT WA	S UNDERLYING CAUSE OF DEATH	20b. DE:	SCRIBE HOW INJUR	Y OCCURRED.	(Enter nature of injury in	Part I ar Pa	rt 11 af item 1B.)			
	(E)		MEDICAL EXAMINER)									
	MEDICAL	20c. TIME OF INJ	URY Manth, Day, Year		JURY OCCURRED		CE OF INJURY (Hame, farm		(City ar tawn)	(Cau	inty)	(State)
	ME	Haur o.	10	While of work	Nat While I	Tacro	ory, street, affice bldg., etc.	1	1	1.	1	
			fy that (1) (this ha			ed from		95	· 814	190	, that (I)	(we) la
			eceased alive an_	1814	195	, and that	death accurred at	12:35 N	, fram causes	and an th		. /
		22a. SIGNATURE	111	X						22b DA	E SIGNED	7
			100	MAY	Sold	M.D	D. PHYS.	MED. DIRECTOR	STAFF PHYS.	3 8	1416	
		22c. PHYSICIAN'S		110	1		22d. ADDRESS				111	
		NAME (Type	Charles	H. Ligo	n, M.D.		Medical (Center	, Sandy	Spring	d, Md.	1
1	230	BURIAL, CREMATI	ON. 23b. DATE TH	HEREOF	230 NAME OF	CEMETERY OR	CREMATORY .	23d. L0	OCATION (City or To	wn)	(Caunty)	(State)
B		REMOVAL (Specif			St. J		77.14 (F)		lney			
N	24	_FUNERAL DIRECTO					2So. REC'	D BY REGIST		EGISTRAP'S SI	GNATURE 1	. 1.0
7		Francis	H. Barber	Layto	ns ville,	Md.	DATE	AUG	8 1967	fula	res fr	9
1 1 2							1 DAIL		_	AS		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral

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DAN CONTRACTOR OF THE PROPERTY 5021 ,8 , hed 12 and 12 and Tone S. H. H. . Oile Tate Fing 5212 Parkings for erson beurn. No. 100m. 180-46-3756 Narhers F. Managara Hoolus Lite, Md. allenger v.a. to the Grammitten Mar. o, 1830 Grant Hill Ordsettry Saitland, 1940. Nonephronology and Jack Mar., 0.3. MARYLAND STATE DEPARTMENT OF HEALTH

Items 18-21 Film 393

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OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECOR RESTON STREET, BALTIMORE 1, MARYLAND funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY by the and 2 death, MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN outside corporata limits, write RURAL and give write RURAL englacive O d. NAME OF HOSPITAL OF INSTITUTION (if not in hospital. IS RESIDENCE papers. rag ON A FARM? YES NO 3. NAME OF Dey Month Yeer DECEASED OF (Typa or print) DEATH 26 19 67 August and cor 5. SEX AGE (In yeers | IF UNDER 1 YEAR | IF UNDER 24 HRS. NEVER MARRIED B. DATE OF BIRTH MARRIED wif last birthday) Hours # WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work 11. BIRTHPLACE (County & State, or foreign country) 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) attending ph Then please r 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT (Yas, no, or unknwn) | (If yes give wer or detes of service) 18. CAUSE OF DEATH [Enter only one ceuse per line for (e), (b), end (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Multiple congenital anomalies IMMEDIATE CAUSE (e) has been signed he burial-transit i DUE TO Conditions, if eny, which geva rise to immediate ceuse DUE TO (a), stating the underlying the PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(+) 19. WAS AUTOPSY PERFORMED? NO 2De. ACCIDENT WAS UNDERLYING TI 2Db. DESCRIBE HOW INJURY OCCURED. OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED | 2De. PLACE OF INJURY (Home, farm, 1 20c. TIME OF INJURY 2Df. (City or town) (County) (Stete) Month, Day, Yeer be retained by ECTOR: After hould be detached fectory, street, office bldg., etc.) Hour a.m. Not While at work et work 21. I certify that on. 26A 22b. DATE 22e. SIGNATURE SIGNED ATTENDING PHYS. DIRECTOR TO HOSPITAL death. Page 4 TO FUNERAL rector, page ADDRESS 22c. PHYSICIAN'S 22d. NAME (Type) 23a. BURIAL, CREMATION, 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF REMOVAL (Specify) Dig a 25a. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) 15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The law requires that the deoth certificate be executed within 24 hours after deoth PLACE OF DEATH 2. USUAL RESIDENCE Where deceosed lived, if institution: Residence before admission) o. COUNTY MARYLAND o. STATE c. CITY OR TOWN (If postside corporate limits, write RURAL and (If outside corporate limits. write BORAL and give nearest town d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS 3. NAME OF First Middle DECEASED OF DEATH (Type or print) S. SEX 7. MARNED 6. COLOR OR RACE NEVER MARRIED 8. DATE OF BIRT AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS lost birthdoy) Hours WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 10o. USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life even if retired) INDUSTRY COUNTRY? andi 182d 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removol. RRETT 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? Address (Yes, no, or unknown) (If yes give wor or dotes of service) cremation, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY DAISET AND DEATH Primary hepatoma IMMEDIATE CAUSE (o) þ DUF TO Hepatic cirrhosis Conditions, if ony, which gove rise to immediate couse (o), DUF TO stoting the underlying couse TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the hospital or attending as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? hos be detached for use Stote Dept. of Heolth Bilateral lobular pneumonia YES X NO this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port 11 of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) (County) Hour o.m. factory, street, office bldg., etc.) Not While at work 21. I certify that (1) (this haspital) attended the deceased fram 19.6 / ta 19, 7, that (1) (400) last 7, and that death accurred at 6:30A M, fram causes and an the date stated above saw the deceased alive an Aug 22o. SIGNATURE 22b. DATE SIGNED M.D. PHYS. DIRECTOR PHYS 22d. ADDRESS 22c. PHYSICIAN'S FUNERAL NAME (Type 5413 CEDAR LANE. JAMES W. EGAN BETHESDA. should 230. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 8-19-67 GATE of HEAVEN CEM. SILVER SPRING. ADDRESS WASH . D. C. 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR VR A15 (4) 25M 1/67 3821 14TH. ST. N.W. DATE AUG

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11183 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY 3 to Poge deloy is ontcomer Montgenzera Ith the State Department c. LENGTH OF STAY IN 16 b CITY OR TOWN c. CITY OR TOWN (If ourside corporate limits, write RURAL and give nearest town). puo PM3 2 Months 135 TUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCI Medical Examiner's Office along with farm ON A FARM? 24 hours after deoth. I'm Item 18. Give Poges YES NAME OF DATE Month Lost Doy Year DECEASED OF oster 196 (Type or print DEATH S. SEX IF UNDER IF UNDER 24 HRS 6. COLOR OR RACE DATE OF BIRTH . AGE 7. MARRIED NEVER MARRIED (In veors birthdoy) last Months Doys Hours deoth WIDOWED DIVORCED ond 2 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (Stote or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? event within 72 hours ofter 1017013 Housewife Home 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME This certificate should be executed within in pencil Andrew Ambuhl Caroline Wicke permit. File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT 901 essLangley Dr. (Yes, no, or unknown) (If yes give wor or dotes of service 'pending" Charles F. Pratt (Son)Sil.Spg., Md.20901 No 577-56-2588 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN buriol-transit the Chief DSUfficency Colonary IMMEDIATE CAUSE (o) please execute the certificate, writing the ward DUE TO 4 Months in ony hroinn posis Conditions, if ony, which gove rise to immediate couse (o), forwarded to DUF TO stoting the underlying couse 0 and 12015 SD nsed PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPS) or removol, PERFORMED? CERTIFICATION NO YES pe 4 should be 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) 3 should PRIMARY Or CONTRIBUTING files. CAUSE OF DEATH cremotion, 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) Yaur Hour o.m foctory, street, office bldg., etc.) Not While FUNERAL DIRECTOR: Poge Poge ot work of work 21. I certify that I took charge of the remains described above, held an Autapsy and in my apinion Inspection Inquiry be retained for Natural causes death resulted fram: Accident Suicide Hamicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER prior SIG NATURE funeral O DEPUTY DEPUTY MEDICAL EXAMINER 🔀 **EXAMINER'S** John G. Ball. Vpm Health NAME (Type) Address (Street, city, town, or county) the 23b. DATE THEREO! NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION (County) (Stote) 9 5 Burial (Specify) Fort Lincoln Cemetery Bladensburg, Md. ADDRESS REDURAR'S SCHA 24. FUNERAL DIRECTOR VR A15ME (5 Joseph Gawler's Sons, Inc., Wash., D. C. 6M 1/67

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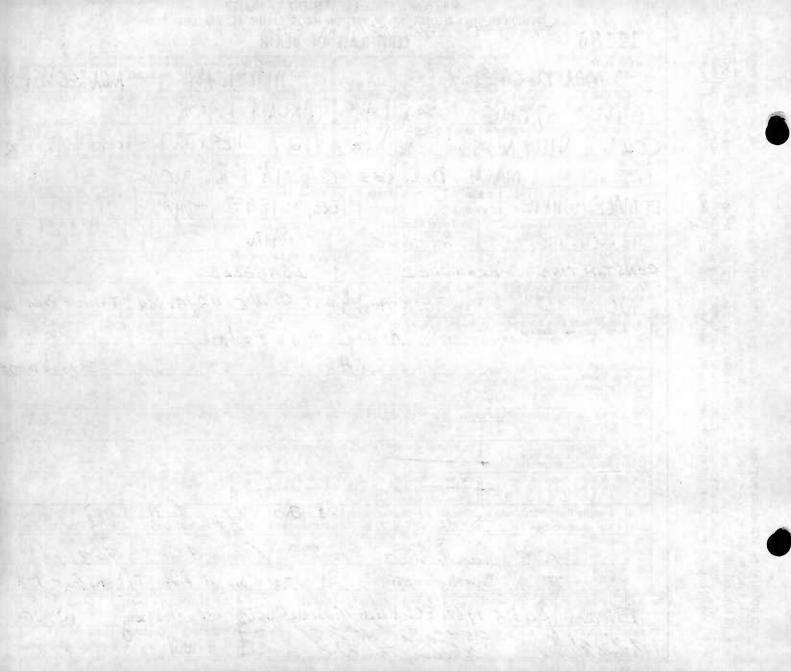
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11186 1185 CERTIFICATE OF DEATH that the death certificate be executed within 24 haurs after death. and campletely filled in by the funeral 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) 1. PLACE OF DEATH Montgomery b. COUNTY Montgomery MARYLAND c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, Swite RURAL and give necrest town) Silver Spring uears e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) d. STREET ADDRESS Pershina Drive 511 Pershing Drive YES NO within NAME OF 4. DATE Middle First Lost Month Doy Year DECEASED Boulianne Maria Gaanon (Type or print DEATH IF UNDER 24 HRS S. SEX 8 DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED NEVER MARRIED birthdoy) Months Doys Hours white July 8 . 1883 temale any WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRY? physician (please during most of working life, even if retired) INDUSTRY pup Canada Own home 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Henri Boulianne Celina Tramley WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address permit. (Yes, no, or unknown) (If yes give wor or dotes of service) 511 Pershing Drive 0 No 219-46-7061 crematian, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) the signed by the burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: arcinomalosis IMMEDIATE CAUSE (o) DUE TO burial, Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse the has been prior to last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) nagnon, CERTIFICATION USe Health NO K YES O FUNERAL DIRECTOR: After this certificate 0 for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING haspital OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, Hour o.m. Not While foctory, street, office bldg., etc.) of work ot work pe to August , 1967, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased from be retained 1967, and that death accurred at 400 M, fram causes and an the date stated above. filed with the saw the deceased alive on. August 220. SIGNATURE 22b. DATE SIGNED X M.D. PHYS DIRECTOR director, page shauld be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 301 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 23o. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Parklawn Cemetery 196 Rockville Maryland 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE Georgia Avenue VR A15 (4) 1967 DAAUG 20 M 1/66 Pumphrey nc.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Them #9 Film #G392 9 18 67 ph & Item #8

CERTIFICATE OF DEATH 11186 the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission o. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN c. LENGTH OF STAY IN 11 outside carperate limits, write RURAL and give nearest town remove corbon papers. Pagary art entry within 72 hours OR INSTITUTION (If not in hospitol, e. IS RESIDENCE ON A FARM? NO X YES NAME OF Middle DATE Month Year DECEASED OLORES Type or print) 19 6 DEATH 6. COLOR OR RACE IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED hirthdoy) Months Doys Hours WIDOWED DIVORCED 1Db. KIND OF BUSINESS OR 1Do. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) physicion c INDUSTRY and HIME 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removol, ISABELLE 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT (Yes, no orunknown) (If yes give wor or dotes of service) DRYBURGH, TAKERIA PARK MI cremotian. signed by the c burial-transit p INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c). PART I. DEATH WAS CAUSED BY: ONSET AND DEATH requires that IMMEDIATE CAUSE (o) by the hospital or attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse the of Health prior to lost. OS 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO certificate for 2Do. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Part 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 2Dc. TIME OF INJURY Month, Doy, Yeor 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While ATTENDING TO FUNERAL DIRECTOR: After ot work 21. I certify that (I) (this haspital) attended the deceased fram_ ro Hospital or Attend Page 4 may be retained saw the deceased alive an 19 67, and that death accurred at_ PM, fram causes and an the date stated abave 220. SIGNATURE 22b. DATE SIGNED director, page 3 shauld be filed v M.D. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Sand 7701 CEMETERY OR CREMATORY 23o. BURIAL, CREMATION 23d. LOCATION (City or Town) (County) 24. FUNERAL REGISTRAR'S SIGNATURE Y REGISTRAR VR A15 (4) 25M 1/67 DATES 196



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

		11106	CERTIFICAT	E UF DEATH	N. A.	100
	1.	PLACE OF DEATH		I 2. USUAL RESIDENCE (W	here deceased lived, If institution: R	esidence before admission)
1		a. COUNTY MONTGOMERY		e. STATE	b. COUNTY	
	-	b. CITY OR TOWN (If outside corporate limits,	MARYLAND	1 1 1 1 1 1		NIGOMERY
		write RURAL and give nearest town)	c. LENGTH OF STAY IN 15	c. CITY OR TOWN (IT outs	de corporate limits, write RURAL	end give nearest town)
-		Silver Sprina	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	SILVER	SPRINGS	1511
0		d. NAME OF HOSPITAL OR INSTITUTION (If not in h	ospital, give street address)	d. STREET ADDRESS		e. IS RESIDENCE
0		HOLY CROSS HO	Spital	75 E. h	JAYNE AUG	YES NO
-	3.	NAME OF FIRST	Middle	Last 4.	DATE Month	Day Year
Ш		(Type or print) SAMUEL	A. G	PASKINS	DEATH 8	27 1967
	5.	SEX 6. COLOR OR RACE 7. MARRIED	NEVER MARRIED	B. DATE OF BIRTH 1907	9 AGE (In years IF UNDER Months	
		M WIDOWED		15-31 MANY	L L L	Days Hours Min.
	10a		IND OF BUSINESS OR	11. BIRTHPLACE (County	State on foreign country 12 C	ITIZEN OF WHAT
	dur		NDUSTRY			DUNTRY?
		1000000	eway Food Store	EN WASHING	TON DC AI	MERICA
- 1	13.	FATHER'S NAME		14. MOTHER'S MAIDEN N	AME	
		William H. Gaskins			Gaskins	
	15. (Ye	. WAS DECEASED EVER IN U.S. ARMED FORCES? 16.	SOCIAL SECURITY NO. 17.	INFORMANT 95 Eas	t Wayne Address Sili	ver Spring.
		no ue	1 81	eanor Gaskins		Md.
	1	18. CAUSE DF DEATH [Enter only one cause per i	ine for (a), (b), and (c), 1	7		INTERVAL BETWEEN
н		PART I. DEATH WAS CAUSED BY:	13-1-01	· Maria	4	ONSET AND DEATH
		6 0 6 X IMMEDIATE CAUSE (a)	monen	Tarcellimo	nia	1 distys
		DUE TO		1. 1.		2006
		conditions, If any, which gave rise to immediate (b)	supragol	you you	willowid	Jan July
-		cause (a), stating the DUE TO			1	
		underlying cause last. (c)				
	CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIB	JTING TO DEATH BUT NOT RELA	TED TO THE TERMINAL DISEA	SE CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY
2	CAT					PERFORMED?
	=	20a. ACCIDENT WAS UNDERLYING [] 2Db.	DESCRIBE HOW INTERV OCCU	DRED (Enter nature of Inlu	y In Part I or Part II of Item 18	
	ERI	OR CONTRIBUTING CAUSE OF DEATH	DESCRIBE NOW INJORT OCCO	KKED. (Enter nature of Injul	y in Fait I of Fait II of Item 16.	,
		(IF EITHER, NOTIFY MEDICAL EXAMINER)				
	MEDICAL	Hour om	factor	CE OF INJURY (Home, farm, ry, street, office bldg., etc.)	20f. (City or town) (Cou	inty) (State)
		p.m. 19 at wor	MOT WHITE I	/	/	
		21. I certify that (I) (this hospital)/attend	ed the deceased from	7/25 19/5	1 to 8/27 19/	Z, that (I) (we) last
		saw the deceased alive on 1 126	1 17	death occurred at 600	M, from the causes and on t	7—,
		22a SIGNATUBE	, and that	death occurred at	22b. D	ALE SIGNED
		CAMPAGE TIBE	my.	ATTENDING MED.	STAFF C	77/67
		22c. PHYSICIAN'S	M.D.	. PHYS. DIRECT	TOR L PHYS. L	7/1
,		NAME (Type) Throthy	TFLIAN	O) II W		Ry gres
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	23a	DESCRIPTION OF THE PROPERTY OF	23c. NAME OF CEMETERY	OR CREMATORY 23	d. LOCATION (City, town or cou	inty) (State)
	- 1	Bureal Ing. 10, 1907	Mt. Olivet		Washington, I	X.
	24.	FUNERAL DIRECTOR Carter Colen	Carteller Spr	ina Md 25AUREC'D'B	PREGISTRAR 256 REGISTRAR	S SIGNATURE
	W		34 Georgia Aver	me DATE	6	0

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death physicion and completely filled in by the funeral en please remove carbon papers. Pages I and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY ONTGOMER o. STATE b. COUNTY MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town) b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 16 write RURAL and give nearest town) FATON d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? ENTURA HVE NO X carbon int, with 3. NAME OF First Middle 4. DATE Lost Month Doy DECEASED OF DEATH (TILNEK LUGUST (Type or print) 196 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. NEVER MARRIED Hours WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired INDUSTRY COUNTRY ?__ US5119 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME NENDER UNENOWA 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT LEFFER TWERAL (Yes, no, or upknown) (If yes give wor or dates of service) CHOWA 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN signed by the burial-transit p PART I. DEATH WAS CAUSED BY ONSET AND DEATH CORONARY IMMEDIATE CAUSE (o) DUF TO Conditions, if ony, which gove HEROSCLEROTK UNKNOWN rise to immediate couse (o). DUE TO stoting the underlying couse be retoined by the hospitol or ottending as the TO FUNERAL DIRECTOR: After this certificate hos been last. 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use OSTATIC NO PERTROPHY 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) foctory, street, office bldg., etc.) Not While 21. I certify that (I) (this hospital) attended the deceased from July 151 , 19 67, to AUGUST 134-1967, that (1) (we) last saw the deceased glive on August 13 19 6 7, and that death accurred at 4.30 PM, from causes and on the date stated above. 22o. SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR directar, poge 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) ILVER SPRING GEORGIA 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION. 23d CATION (City or Town) (County) (Stote) REMOVAL (Specify) 24., FUNERAL DIRECTOR VR A15 (4) 20 M 1/66

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183 11 HEALTH DEPT. P.M.3. Poge TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages land 2 with the State Deportment of amy deloy is and 3 to

pending" in pencil in Item 18. Give pages 1, 2,

This certificate should be executed within 24 hours ofter death. If

the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with term

necessory, please execute the certificate, writing the ward

TO DEPUTY MEDICAL EXAMINER:

Health prior to buriol, cremation, or removal, and in any event within 72 hours ofter death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11190

	PLACE OF DEATH	2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
	a. COUNTY. MONTGOMEIG- MARYLAND	o. STATE Maryland b. COUNTY Montgomere	1
	b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If autside tarparate limits, write RURAL and give nearest tawn)	
	Revil Gaithersburg	Rural Gaithersburg 151	
	d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address)	d. STREET ADDRESS 0. IS RESIDE	NCE
	Long Drast Rel.	Long Droft R1. ON A FAR	SWS
3.	NAME OF DECEASED (Type or print) William D &	loan Jr. 4. DATE Month Doy Year August 26 196	
	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED DIVORCED	8. DATE OF BIRTH 9. AGE (In years Sept-24.19239 ast birthday) yrs. FUNDER YEAR IF UNDER 2 Hours Hours	Min.
	u. USUAL OCCUPATION (Give kind of work done ing most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY 21.5 A	1
13.	FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
	William. D. Glover	Gladue Burdette	
	1 1/11	NFORMANY Address Dogwood Dr.	
(1)	as, na, or unknawn) (If yes give war or dates of service)	Madaline J. Glover Gaithersburg!	Md
		of neck-and Chest Susan Der	ATH
	Canditians, if any, which gave) (b)		
	rise to immediate cause (a),		
1	stating the underlying couse		
	, 17	THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOP	oc v
CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS ARRIVE PERFORM YES IN.	D?
	PRIMARY GOOT CONTRIBUTING TO	(Enter nature of injury in Part I or Part II of item 18.) Nifle In another man	
MEDICAL	20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLA Hour a.m. 4 April 200 Mile Not While 50 fact	CE OF INJURY (Hame, Grm, ory, street, office bldg., etc.) Rural Gaithersburg Mont	tate) - Ma
	21. I certify that I took charge of the remains described above, he		pinion
		ide Nomicide Undetermined monner	
		CHIEF MEDICAL EXAMINER	
	SIGNATURE John G. Ball	M.D. ASSISTANT MEDICAL EXAMINER 22. DATE SI	IGNED
	EXAMINER'S NAME (Type) John G BALL M.D.	DEPUTY MEDICAL EXAMINER A 8/26/67	
00		Address (Street, city, town, or county)	
230	23. BURIAL, CREMATION, PREMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR		10)
2	BUTIST AUGZETTON CLAYES OUT		5
1	316 E. Diamond	hre 250 RECT BY REGISTRAR 255 POURTRES SIGNATURE	4

VR A15ME (5)

5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11180 CERTIFICATE OF DEATH 11191 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE Maryland b. COUNTY Montgomery Montgomery MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b write RURAL and give nearest tawn) 14 years Bethesda Bethesda d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? Weymouth Street 10507 Weymouth Street YES NO SE 3. NAME OF First Middle 4. DATE Month Lost Doy Year DECEASED ELIZABETH GOOKEN Aug. 19 67 (Type or print) DEATH 6. COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH lost birthday) Months Hours Female White Dec. 23,1892 WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Lowell. Mass. U. S. Housewife 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John Tracy Margaret Curley Husband 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service Same as Item 2. 215-48-3826 George A. Booken 18. CAUSE OF DEATH (Enter only one couse per line for (g), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: ONSET AND DEATH HRTE Rios de Rosi IMMEDIATE CAUSE (o) DUE TO BR. ASTHOYA DUE TO MONTH S FOOT. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form (City or town) (Stote) (County) Hour 'o.m foctory, street, office bldg., etc.)

Conditions, if ony, which gove rise to immediate couse (a) stoting the underlying couse lost. 20o. ACCIDENT WAS UNDERLYING

1954, to Hus

17, 19 67, that (I) (we) last 19 67, and that death occurred at 200 M, fram causes and an the date stated abave.

(Stote)

21. I certify that (I) (this haspital) attended the deceased fram saw the deceased alive an 22o. SIGNATURE

23o. BURIAL, CREMATION,

Burial transit

22c. PHYSICIAN'S NAME (Type)

23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF

Granam

PHYS. 22d. ADDRESS 10101

M.D.

ATTENDING

DIRECTOR

23d. LOCATION (City or Town)

(County)

22b. DATE GRED

TO FUNERAL VR A15 (4) 25M 1/67

DIRECTOR:

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours

Page 4 may be retained by the haspital ar attending physician.

O HOSPITAL

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attending physician sermit. Then please

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burial, crematian,

Dept. af Health priar ta

burial-transit

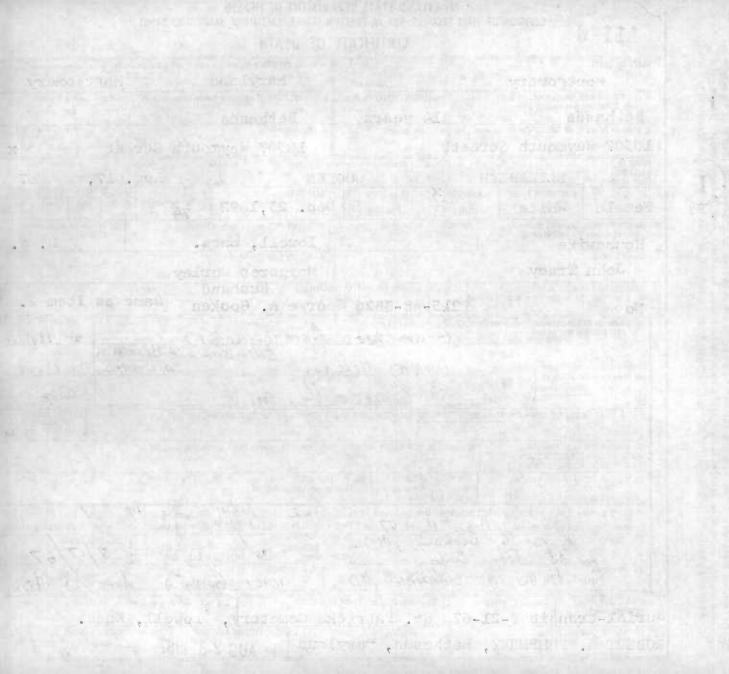
and

S. SEX

24. FUNERAL DIRECTOR **ADDRESS** Maryland PUMPHREY. Bethesda.

8-21-67

St. Patricks Cemetery. Lowell. Mass. 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR Minereles



IO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11192

11191	CERTIFICATE	OF DEATH	11192
1. PLACE OF DEATH •. COUNTY		2. USUAL RESIDENCE (Where decea	sad lived, If Institution: Residence before edmission
b. CITY OR TOWN (if outside corporete limits, write RURAL and give (carast town)	c. LENGTH OF STAY IN 16	c. CITY OR JOWN (If outside corporet	Wonlgomery
d. NAME OF HOSPITAL OR INSTITUTION (if not in	Huns - 3 mas	Ashton d. STREET ADDRESS	•. IS RESIDENCE
Brooke Grove Tounda		Colesville Road	ON A FARM? YES NO L
3. NAME OF DECEASED (Type of print)	Middle	Lest 4. DATE OF DEATH	Amonth Par 1967
5. SEX 6. COLOR OR RACE 7. MAR	RIED NEVER MARRIED B.	DATE OF BIRTH 9. A	GE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. st birthday) Months Days Hours Min.
10e. USUAL OCCUPATION (Giva kind of work 10b	WED DIVORCED . KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or tora	yrs.
done during most of working lile, even if retired) 13. FATHER'S NAME		Augusta, Arkan	sas u.S.
7. M. Pattan		9da Sullivan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (Ilyesgiva war or dates ol sarvica)	16. SOCIAL SECURITY NO. 17. IN	FORMANT O	Address Of Of the
1B. CAUSE OF DEATH Enter only one cause po	ar the for (a) th), end (c).)	Trancis D. Gordon	- Colesville Ad-Hshlon, Wid
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) DUE TO	Dam on	spine fadine	Loang.
Conditions, if eny, which gave rise to immediate cause	Bulkerin	of GAL Pr	send 1420
(e), stating the underlying ceuse last.	M		
PART II. OTHER SIGNIFICANT CONDITIONS C	ONTRIBUTING TO DEATH BUT NOT	RELATED TO THE TERMINAL DISEASE CON	NDITION GIVEN IN PART 1(4) 19. WAS AUTOPSY PERFORMED?
PART II. OTHER SIGNIFICANT CONDITIONS CONDIT	DESCRIBE HOW INJURY OCCURRED	. (Enter nature of injury in Pert I or Part II o	
Hour e.m.		E OF INJURY (Homa, farm, y, streat, offica bldg., atc.)	fown) (County) (State)
	ended the deceased from	///27 #	, 19 6.1, that (I) (we) las
saw the deceased alive on		ATTENDING MED.	e causes and on the date stated above. STAFF PHYS.
22c. PHYSICIAN'S NAME (Typa)	Mass A.	22d. ADDRESS	pring, Mil.
23e. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Aug. 10 196		R CREMATORY 23d. LOCATIO	ON (City, town or county) (State)
24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS		R 25b. REGISTRAR'S SIGNATURE

VR A15 (4) 20M 5-63

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rancis H. Barber Lytonsville

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH deoth). PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY b. COUNTY ely filled in by the fune bon papers. Poges 1 a within 72 hours after d MARYLAND 24 hours ofter b. CITY OR TOWN (If outside corporate limits, write RURAL and give peorest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown) HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS law requires that the deoth certificate be executed within 3. NAME OF Middle 4. DATE Month DECEASED OF DEATH (Type or print) AGE (In years Jost birthdoy) IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH NEVER MARRIED WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR and in 11. BIRTHPLACE (County & Stote, proforeign country) physician o during most of working life, even if retired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAM cremotian, or remavol, nawrence 16 SOCIAL SECURITY NO. 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT (Yes, no, or unknown) I(If yes give wor or dotes of service) 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the buriol-transit p buriol, cremoti PART I. DEATH WAS CAUSED BY: Carellac IMMEDIATE CAUSE (o) by the hospital or attending physicion. DUE TO earlimasula dineare Conditions, if ony, which gove rise to immediate couse (o), DUF TO stoting the underlying couse the 05 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) TO FUNERAL DIRECTOR: After this certificate 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. 20d. INJURY OCCURRED foctory, street, office bldg., etc.) Not While of work of work ATTENDING 21. I certify that (1) (this haspital) attended the deceased from . Le 1967, to aug, 13 be retoined director, page 3 should should be filed with the saw the deceased alive an ang. 12 22o. SIGNATURE MED. DIRECTOR ATTENDING M.D. 22d. ADDRESS 22c. PHYSICIAN'S McCormick NAME (Type) Robert

10 19. WAS AUTOPS PERFORMED? NO YES (County) (State) 1967, that (M (we) last 19 67, and that death accurred at 8.45 AM, from causes and an the date stated above. 22b. DATE SIGNED 11161 New Hampshire ave Silver SpringsMd 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Wheaton Montgomery Aug 16, 1967 Gate of Heaven Cemetery Md. Buria 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR ADDRESS Marley Hyattsville, Md. F. Gasch's Sons

11194

12. CITIZEN OF WHAT

GIKO MAI

e. IS RESIDENCE ON A FARM? YES NO PA

Year

IF UNDER 24 HRS

INTERVAL BETWEEN

ONSET AND DEATH

VR A15 (4) 25M 1/67

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erwe widle ex-	and Editor		included in		

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11194 11195 CERTIFICATE OF DEATH 2 be executed within 24 haurs after death and completely filled in by the funeral Lemove carbon papers. Pages I and in ony event, within 72 hours offer deat 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) 1. PLACE OF DEATH a. COUNTY b. COUNTY Montgomery Maryland Montgomery MARYLAND b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b Rockville Damascus d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Potomac Valley Nursing Home YES NO X 25900 Ridge Rd 3. NAME OF 4 DATE Year DECEASED Lillie M. Hager (Type or print) 12 19 67 Aug. DEATH 6. COLOR OR RACE 9. AGE (In years I YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH last birthday) Months Doys Hours White WIDOWED T Female DIVORCED 24.7887 10a, USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (Caunty & State, ar fareign cauntry) 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR Toge - may be received. After this certificate has been signed by the attending physician of the control of the physician of the part of the please of the burial-transit permit. Then please during most af warking life, even if retired)
Housewife INDUSTRY COUNTRY? that the deoth certificate Own home Montgomery Co., 13. FATHER'S NAME removol, Edward Thompson Margaret Purdum IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unknawn) (If yes give wor or dates of service) 215-46-3723 Mrs George G. Matthews, Falls Church 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-tronsit ONSET AND DEATH Advanced Arteriosclerotic Cardiovascular Disease IMMEDIATE CAUSE (a) with Large Fusirorm Aaneurysm . Hypertension and ? Conditions, if any, which gove Terminal Cardiac Decompensation. rise ta immediate cause (a), DUE TO stoting the underlying cause Poge 4 may be retoined by the haspitol ar offending last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO * 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (State) Haur a.m. factory, street, office bldg., etc.) at wark 2). I certify that (I) (this haspital) attended the deceased fram Peb. 14, 19679 ta August 12, 1967, that (1) (374 last director, page 3 shauld should be filed with the saw the deceased alive an Fagust 12. 19 67, and that death accurred at 10:45M, AMm causes and an the date stated above. 22a. SIGNATURE 22b. DATE SIGNED ATTENDING X 8/12/67 PHYS. DIRECTOR PHYS 22d. ADDRESS 9701 Church Street 22c. PHYSICIAN'S M. McKendree Boyer. NAME (Type) Damascus. Maryland. 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL CREMATION. (County) (State) REMOVAL (Specify)
Burial Aug. 15.1967 Damascus Meth. Damascus, Md. 24. FUNERAL DIRECTOR ADDRESS 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66 Molesworth, Damascus, Md. Mianes AUG 1967

A CARLO DESCRIPTION OF STREET OF STREET, STREE STANDED OF LESENSSEES SEE STEEL SECTION OF STANDARD CONTRACTOR OF THE SAME AND THE STATE OF THE SAME OF TH - OR FREEDOM SELLED AND CONTROL OF TARREST manufactured and the state of t FILM E. 2 SYDD BOOKINGSON AND LINES ENGLE, AUGUST LENGT. S. Justing and Mart. Is .. it • 100 (100) AND A SOURCE OF THE SECOND OF

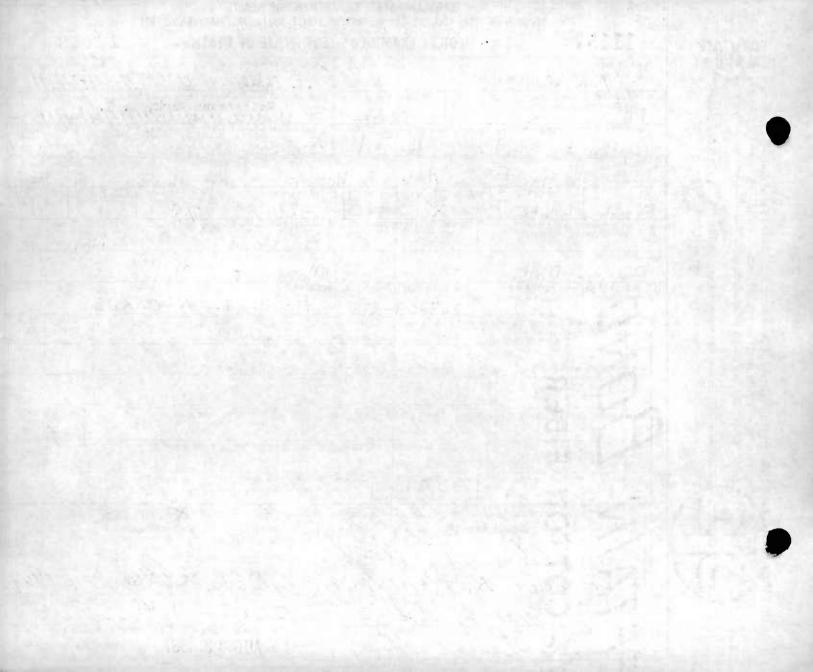
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11195 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 11196 'HEALTH DEPT. 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Montgomery Montgomery MARYLAND b. CITY OR TOWN (If autside corparate limits, c LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) PM3. F Silver Spring Silver Spring d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM2 Office along with form 8484 16th Street, #907 the State D Holy Cross Hospital NO in pencil in Item 18. Give Pages This certificate shauld be executed within 24 hours after death. NAME OF Middle 4. DATE Month Lost Day Year DECEASED LEE POE HART 19 67 August (Type or print) DEATH 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 68 birthday) Manths Hours White 1/8/1899 Male WIDOWED DIVORCED 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDUSTRY COUNTRY? during most of warking life, even if retired) Washington, D. C. U.S. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME George Hart Mamie Pie (Wife) 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT event within 72 (Yes, no ar unknown) (If yes give war or dates af service) 577-09-8176 Hazel Hart 8484 16th St., Sil. Sp., Md. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per ling ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise ta immediate cause (a). farwarded to = DUE TO stating the underlying cause PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? removal, the certificate, pe 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.) 3 should PRIMARY | or CONTRIBUTING | 5 EDICAL EXAMINER: CAUSE OF DEATH cremation, 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Not While factory, street, affice bldg., etc.) 5 may be retained far yaur 10 FUNERAL DIRECTOR: Page please execute ot wark 21. I certify that I taak charge of the remains described above, held an Autapsy Inspection X Inquiry 1 and in my apinian Natural causes death resulted from: Suicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE NAME (Type) 230. BURIAL, CREMATION, REMOVAL (Specify)
Burial NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or To D. C. 8-4-67 Glenwood Cemetery Washington, 25g. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15ME (5) Charles A. PUMPHREY, Bethesda, Maryland 1967 DATAUG 6M 1/67

1.50 0 4.40 T bongwish ייסתל בחנים ביייי privat vevill median govilla Skell loth street, file followed asome to FARS L James L LANS 3.0 1/8/1.59 95.00 ashin ton, 1. U. gran from and of other stroll of one Monel Hort West 16th St., Stl. Syon Isnall Tes biron seal liker Coverly many heriener vienary artery Heart December. That's both a sale, large and was a to that

MARYLAND STATE DEPARTMENT OF HEALTH

ALC: 1967 - Dal times and . Circle aconstine . Source Marie Stranger Brown, Mich. 2.2. - Marie Stranger Stranger

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FOR STAT	E		T+em 2 Film G392 8/25/67 kk	198
HEALTH DE	PT.	1.	PLACE OF DEATH D. COUNTY MONTGOMERY MARYLAND 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence of STATE No. Y. O. STATE N	e before odmission)
oth. If any deloy is oges 1, 2, and 3 to the form PM3. Page State Deportment of			b. CITY OR 10WN (If autside carparate limits, write RURAL and give write RURAL and give peorest tawn) Takoma C. LENGTH OF STAY IN 16 C. CITY OR 10WN (If autside carparate limits, write RURAL and give peorest tawn) Takoma C. CITY OR 10WN (If autside carparate limits, write RURAL and give peorest tawn)	1 MSHE 693
th. If a sign form form	71		1. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) Washington Sanitatium & Hospital 8505/Springaria Routh NAME OF Lost Pare Month	ON A FARM? DOV Year
hours ofter deoth. tem 18. Give Poge Office along with f			Type or print) Margaret NMN Heberton DEATH Avaist SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 18. DATE OF BIRTH 9. AGE (In years I FUNDER)	9 19 67 YEAR IF UNDER 24 HRS.
24 hours ofter deoth. I in Item 18. Give Poges r's Office along with for es 1 and 2 with the state			- emale White WIDOWED DIVORCED 1 - 26-88 79 yrs. 1	Doys Hours Min. IZEN OF WHAT JNTRY?
d within 24 in pencil in 1 Exominer's (hours ofter deo		FATHER'S NAME 14. MOTHER'S MAIDEN NAME	untry? Imer.
be executed within "pending" in pencil nief Medical Exomine	within 72 ho		WAS DECEASED PAR IN U.S. ARMED FORCES? s, no, or unknown) (If yes give wor or dates of service) 027-09-8518 HOSPITAL RECORDS	
	event with		18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Acute, bilateral, pneumonitis; UP 22 X DUE TO	INTERVAL BETWEEN ONSET AND DEATH
This certificate should cote, writing the word be forworded to the Ct be used as a burial-tre			Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse lost. (b) Anemia; Arteriosclerotic heart disease DUE TO (c)	
0 0	removal, o	ATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)	19. WAS AUTOPSY PERFORMED? YES NO
E = =	10	AL CERTIFICATION	2Do. EXTERNAL CAUSE WAS PRIMARY \(\text{O} \) or CONTRIBUTING \(\text{C} \) CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)	
Z = 4 7 9	cremotion,	., MEDICAL	20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19 20d. INJURY OCCURRED While of work of w	
MECCAL EXAM please execute th director. Page 4 ertained for your DIRECTOR: Page	10		21. I certify that took charge of the remains described above held on Autopsy , Inspection , Inquiry death resulted from: Natural causes , Accident Suicide , Homicide , Undetermined manner	and in my apinion]
O DEPUTY MACKA necessory, please es the funeral director. S moy be retained	Heolth prior to		EXAMINER'S BELDEN R. READIN D. ASSISTANT MEDICAL EXAMINER DEPUTY	22. DATE SIGNED 29 1967
TO DEPUTY necessory, the funeral 5 may be 10 FUNERAL	Heolf	230	BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City of town) (S-11-67 and the first for free free free free free free free	(County) (Stote)
VR A15ME	(5)	24	EUNERAL DIRECTOR ADDRESSE ADDRESSE 250. REC'D BY REGISTRAR 250. REGISTRAR'S SIL	



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY MARYLAND c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If autside carparate limits. c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest/tawn) write RURAL and give negrest town d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? papers hin 72 YES NO X 3. NAME OF 4. DATE Last Day Year DECEASED (Type or print) DEATH S SEX TIF UNDER I YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH AGE (In years **NEVER MARRIED** Manths last birthday) WIDOWED DIVORCED and 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, ar fareign cauntry) during most of working life, even if retired)

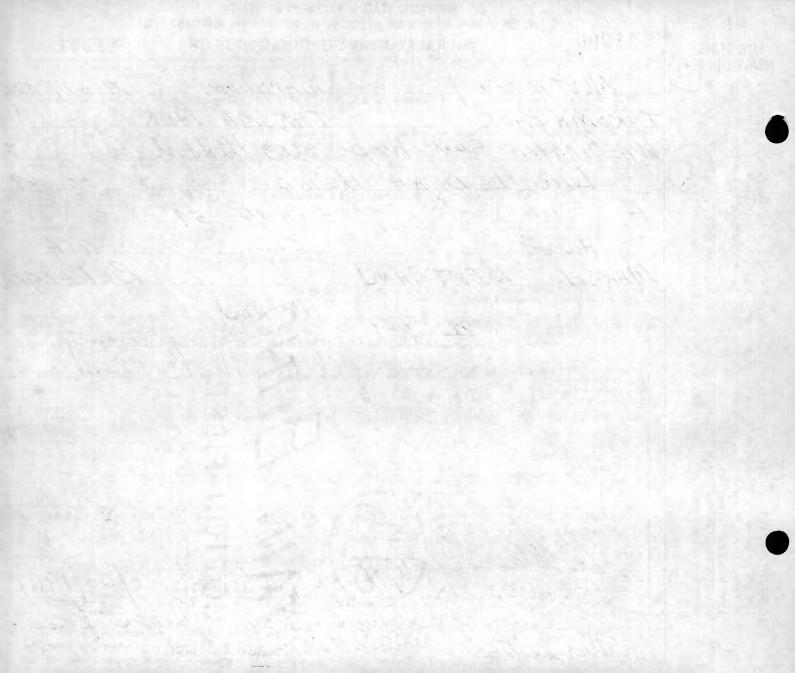
DEA CONESS ANDUSTRY. 13. FATHER'S NAME MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMAN (Yes, na, ar unknawn) (If yes give war ar dates of service) Б 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) signed by DUE TO Conditions, if any, which gove rise ta immediate cause (a), DUE TO stating the underlying couse as the has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) of far use af Health NO YES certificate 20o. ACCIDENT WAS UNDERLYING ☐ GR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) (County) factory, street, affice blda., etc.) Nat While at work TO FUNERAL DIRECTOR: After 21. I certify that (I) (this haspital) attended the deceased from 19 67, ta 19.67, that (I) (we) last 67, and that death accurred at 435A M, fram causes and an the date stated above saw the deceased alive an. 22o. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. PHYS. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S Fred A. Gill NAME (Type) directar, shauld b 23a. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) Fort Lincoln Prince Georges Co ADDRESS 4 Ga., Ave. 250. REC'D BY REGISTRAR VR A15 (4) 25M 1/67 Juneral Home Silver Spring, Mate

Control of the second of the s

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11199 11200 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) popers. Pages 1 iin,72 hours ofter MARYLAND b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn) CLENGTH OF STAY IN 16 WhEaton 2 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Randolph Hills Nursina Home within, 230 YES NO F 3. NAME OF Middle 4. DATE Manth Day Year DECEASED Mary 1967 (Type or print) Augusi ar DEATH B. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED AGE (In years remove last birthday) Manths Davs Haurs WIDOWED DIVORCED 1890 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, ar fareign cauntry) 12. CITIZEN OF WHAT deoth certificate be during most of working life, even if retired) INDUSTRY Washington 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or removal, ottending phy 17. INFORMANT Bernhardt Augustus Neitzen 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 94th Avenue (Yes, pa, or unknawn) (If yes give war ar dates of service Seabrook. burial, cremation, IB. CAUSE OF DEATH (Enter anly one cause per line far (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) offending physicion. DUE TO signed ! Canditians, if any, which gove rise to immediate couse (o), DUE TO stoting the underlying couse for use as the l PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AUTOPSY PERFORMED? Genera 112 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) at home going from KhaiR detoched 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, (City ar tawn) (Caunty) 20c. TIME OF INJURY Manth. Dov. Year (State) Nat While Haur a.m. factory, street, affice bldg., etc.) 1967 Wheaton 21. I certify that (1) (this hospital) attended the deceased from. 1967 be retoined 1967, and that death occurred at 6 95 M, from causes and on the date stated above DIRECTOR: sow the deceosed olive on_ 22a. SIGNATURE 22b. DAJE SIGNED DIRECTOR PHYS. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S TO FUNERAL NAME (Type) Whealan, Ma AYMON 23a. BURIAL, CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) REMOVAL (Specify) Cedar Hill Cenetery Suith 840 DRESS Georgia Hue. 25d. RECD BY REGISTRAR Suitland Hua 23 1967 24. FUNERAL DIRECTOR Thomas 25b. REGISTRAR'S SIGNATURE Inc. Juneral Homedilver SpreateAUG arner C. Pumpticey.

State 30 10 March 19 30 11 the state of the s the size. It was the successories that the Land, Mo - 19 The later with the same of the

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11200 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 11201 HEALTH DENY. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY 2, and 3 to PM3. Page b. COUNTY any delay is MARYLAND OR TOWN (If outside corporate limits, write RURAL and give nearest town) NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS farwarded to the Chief Medical Examiner's Office along with farm YES 24 hours after death. in Item 18. Give Page NAME OF 4 DATE Manth Day Year DECEASED (Type ar print) DEATH permit. File pages land2 with 5. SEX AGE (In years last birthdoy) 7. MARRIED DATE OF BIRTH IF UNDER 1 YEAR Manths Dovs Haurs death. WIDOWED DIVORCED 1Da. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR (Stote ar fareign cauntly) 12. CITIZEN OF WHAT during mast of working life, even if retired) INDUSTRY COUNTRY? 13. FAJHER'S NAMI 14. MOTHER'S MAIDEN NAME within 72 haurs WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give war ar dotes of service) 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), INTERVAL BETWEEN event PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) writing the ward This certificate shauld DUE TO any Conditions, if ony, which gove rise ta immediate couse (a). DUE TO stoting the underlying couse remaval, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PEREORMED? please execute the certificate, YES [4 shauld be 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II af item 18.) 3 shauld PRIMARY ar CONTRIBUTING 0 CAUSE OF DEATH. crematian, 2Dc. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 2De. PLACE OF INJURY (Hame, form, (City or town) (County) (State) Hour o.m. foctory, street, office bldg., etc.) far vaur Not While may be retained far your FUNERAL DIRECTOR: Page ot work ot work 21. I certify that I taok charge af the remains described above, held an Autapsy Inspection X and in my apinian Natural causes the funeral directar. deoth resulted from: Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED priar ASSISTANT MEDICAL EXAMINER SIGNATURE Health NAME_(Type) ddress (Street, lit (town of tounty) 230. BURIAL PREMATION. 23d. LOCATION (City or Town 50 REMOVAL (Specify) 24. RUNERAL DIRECTOR ECD BY REGISTRAR ASB. REGISTRAR'S SIGNATUR VR A15ME (5) 6M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11202 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death filled in by the funeral papers. Pages 1 and 2 hin 72 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution; Residence before admission) o. STATE Maryland b. COUNTY Montgomery o. COUNTY Montgomery MARYLAND 3 WEEKS 2 day c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) Wheaton Wheaton e. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS within 72 ON A FARM? filled Holy Cross Hospital 3126 Helsel Drive YES NO TY n any event with 3. NAME OF First Middle 4. DATE Lost Year and completely DECEASED Helsel, Sr. Earl James 1967 August (Type or print) DEATH IF UNDER 1 YEAR | IF UNDER 24 HRS. S. SEX 8. DATE OF BIRTH AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED birthdoy) Male W Feb. 24, 1901 WIDOWFD DIVORCED JOb. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT and in COUNTRY? Pennsylvania; Blair Co. 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME ar remayal, George Helsel Clara Smith 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 2. INFORMANT Helsel 16. SOCIAL SECURITY NO. Helsel Dr., daughter (Yes, no, or unknown) (If yes give wor or dotes of service) 579-22-8487 Mrs. LaGretta Glowacki -None crematian, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c). burial-transit ONSET AND DEATH PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse by the haspital or attending the has been priar to lost. as PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPS)
PERFORMED? NO P certificate 20o. ACCIDENT WAS UNDERLYING T 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) 21. I certify that (1) (this hospital attended the deceased fram be retained saw the deceased alive and and that death accurred of 450 M. from causes and an the date stated above TO FUNERAL DIRECTOR: 22b DATE SIGNED 220. SIGNATUR ATTENDING M.D. PHYS DIRECTOR PHYS. director, page shauld be filed 22d. ADDRESS 22c. PHYSICIAN NAME (Type) 2309 Shoretield Wheaton Maryland DATE THEREOF 23d. LOCATION (City or Town) (County) 23o. BURIAL CREMATION (Stote) Burial (Specify) Parklawn Cemetery Rockville. Maryland . 1967 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE Charles VR A15 (4) 25M 1/67 Silver Spring.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11203

	o. COUNTY MARYLAND O. STATE D. COUNTY MARYLAND							
		b. CITY OR TOWN (If outside corporate limits,		c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tow				
	13	write RURAL and give nearest town) Rockville		Del Mar		42,5		
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddre	(22	d. STREET ADDRESS				
90		Potomac Valley Nursing Home		1266 Cuch	are Drive	ON A FARM? YES NO		
		NAME OF First Midd	lle	Lost	4. DATE Mon	th Doy Year		
		(Type or print) Catherine S.		nderson	DEATH August	10 19 67		
	S. :	SEX 6. COLOR OR RACE 7. MARRIED NEVER M		B. DATE OF BIRTH	9. AGE (In years Slest birthdoy)	Manths Doys Hours Min.		
		Female White WIDOWED X DI	VORCED #	eb.19,1885	8.2. pinnedy) yrs.			
	10o duri	b. USUAL OCCUPATION (Give kind of work done gigg most of working life, even if retired) 10b. KIND OF BUSINESS INDUSTRY	OR	11. BIRTHPLACE (County in New Jen	Stote, or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
41	_	. FATHER'S NAME		14. MOTHER'S MAIDEN N		0011		
		Henry Sciple	2000	?	-Sife to the	Reese		
	15.	. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY es, no, or unknown) (Iff yes give wor or dates of service)	NO. 17. I	NFORMANT	1153 Raft	Slph Rd.		
		No 144-01-2	770 Ma	rguerite H		Lean. Va.		
		18. CAUSE OF DEATH (Enter only one cause per line for (o), th, and (c) PART I. DEATH WAS CAUSED BY:		1101122 2011	-	INTERVAL BETWEEN ONSET AND DEATH		
		IMMEDIATE CAUSE (a)	con fr	icecimon	a	3 DAYS.		
		Conditions, if ony, which gove) UE TO Conditions	13000111	Par Here	mbosis (mo	Utille 5 URS		
		rise ta immediate cause (a),	-	de vious		770		
'n		stoting the underlying couse (c) Generalis	ed a	reversele	regis	10 4Rs.		
	之	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT N	OT RELATED TO 1	THE TERMINAL DISEASE CON	IDITION GIVEN IN PART 1(o)	19. WAS AUTOPSY PERFORMED?		
2	IFICATION					YES NO X		
	CERT	200. ACCIDENT WAS UNDERLYING \(\) 20b. DESCRIBE HOW INJ OR CONTRIBUTING \(\) CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	URY OCCURRED.	(Enter noture of injury in I	Port I or Port II of item 18.)			
	MEDICAL	20c. TIME OF INJURY Manth, Doy, Yeor Hour a.m. p.m. 19 20d. INJURY OCCURRED While Not While of work of wark	foct	CE OF INJURY (Home, farm ory, street, office bldg., etc.)	, 20f. (City or town)	(County) (State)		
		21. I certify that (I) (this hospital) attended the dece saw the deceased alive an 77/67 19		7/25/67,1 death occurred at		7, 19, that (I) (we) last and an the date stated abave.		
H		220. SIGNATURE), M.	ATTENDING	MED. STAFF DIRECTOR PHYS.	22b. PATE SIGNED		
1		22c. PHYSICIAN'S NAME (TypeHenry C. Scruggs		5413 Ced	ar Lane-Beth	esda, Md.		
-	230		F CEMETERY OR	CREMATORY .	23d. LOCATION (City or To	(County) (Stote)		
	E	REMOVAL (Specify) Burial 8/12/67 West	Laurel	Hill	Philadelph:			
	T24	4 FUNERAL DIRECTOR System Wheeler Funeral Home-1331	Rockvi	lle Pike	BY REGISTRAR 2Sb. RI	EGISTRAR'S SIGNATURE Quedge		
		Rockville.Md.		DATE	AUG 1 4 1961	1		

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the fadirectar, page 3 should be detached far use as the burial-transit permit. Then please remove rarbon papers. Pages should be filed with the State Dept. of Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after Page 4 may be retained by the haspital ar attending physician. VR A15 (4) 25M 1/67

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11204

	44203	CERTIFICATE	OF DEATH		
1.	. PLACE OF DEATH		2. USUAL RESIDENCE (Where deced	ased lived, if institution: Resi	idence before odmissian)
1	o. COUNTY	MADVIAND	a. STATE	b. COUNTY	11
/ -	b. CITY OR TOWN (If autside carparate limits)	MARYLAND c. LENGTH OF STAY IN 16	c. CITY OR TOWN Of autside corpor	oto limita unita DUDAL and	Manto.
	write RURAL and give nearest Jawn)	C. LENGTH OF STAT IN 15	c. CITY OK TOWN OF durside corpor	ofe limits, write KUKAL and	give negrest town)
T	1 a Koma Park		11ensingto	70	15.1
	d. NAME OF HOSPITAL OR INSTITUTION (If not in ho	ospital, give street address)	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?
16	Nashmaton Danitariu	m & Hospital	10100 Gate	5 CIVE	YES NO
3	. NAME OF / First	Middle	Lost 4. DATE		Day Year
	(Type or print) Thomas	5 4	ensley OF DEATH	* august	- 31 1967
S					DER 1 YEAR IF UNDER 24 HRS.
	1/1	DOWED DIVORCED	10/10/190	last birthday Manth	ns Days Haurs Min.
1/	Tuic Touris		10/10/10	6 8 yrs.	CITIZEN OF MILLAT
	0o. USUAL OCCUPATION (Give kind of wark dane uring most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or f	oreign country)	COUNTRY 2
L			Va.		U.S.H.
1	3. FATHER'S NAME	,	14. MOTHER'S MAIDEN NAME		
	Brown low He	ensleu			
	S. WAS DECEASED EVER IN U.S. ARMED FORCES?		NFORMANT	Address	0
((Yes, no, or unknown) (If yes give war or dates of service	e) // 1/a	chilat Hannes	1- 76m1	parsoll Que
=	IB. CAUSE OF DEATH (Enter anly ane cause per	list for (st) (h) and (s)	Spiral Nechia	3 /000	INTERVAL BETWEEN
	PART I. DEATH WAS CAUSED BY:	.//	0+1-11-7	- n)	ONSET AND DEATH
	IMMEDIATE CAUSE (a)	(ancer to	of the very	allac	
	DUE TO	1.0	lot the I	und	Almhus
	Canditions, if any, which gave rise to immediate couse (a), (b)	(across to	1		1
	stoting the underlying couse DUE TO	evith mot	Vitacia		4 4 4 4
	last. (c)				
2	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIB	UTING TO DEATH BUT NOT RELATED TO J	HE TERMINAL DISEASE CONDITION GIV	/EN IN PART 1(o)	19. WAS AUTOPSY PERFORMED?
CATION	Physedohyperburat	hyroidism d	ue to Cancer).	YES NO
<u>u</u>	20g. ACCIDENT WAS UNDERLANG 🗆 /	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Pa	art II of item 18.)	<u> </u>
CERT	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			Name of the	
- V	20c. TIME OF INJURY Month, Day, Yeor	20d. INJURY OCCURRED 20e. PLAC	E OF INJURY (Hame, form, 20f.	(City or town)	(Caunty) (Stote)
MEDICAL	Haur a.m.	While Nat While facto	ry, street, office bldg., etc.)	(city of town)	(5,016)
1	p.m. 17	at work L at wark L	1	<u> </u>	13 1
	21. I certify that (I) (this hospital)				9_6/that (1) (we) la
	sow the deceased olive on	1.3/ 196/, and that	death accurred at 4:40 A		
	220. SIGNATURE D	1	ATTENDING MED.	STAFF 22b.	DATE SIGNED
	Clan 1 X	(M.D	PHYS. DIRECTOR	PHYS.	13/167
	22c. PHYSICIAN'S	RC- us	22d. ADDRESS	1 1 11	DE
	NAME (Type) A Lan /	1 Gair PIL	17777 / lap	16 Ave 12/10	ona lar Mo
2	3a. BURIAL, CREMATION, 23b. DATE THEREOF	23c. NAME OF CEMETERY OR C	REMATORY . 23d. L	OCATION (City or Tawn)	(County) (State)
	BURIA KEM AUG. 9	11.967 BIG STONE	E CEM. BIG	STONE GAP	VA.
	24 FLINERAL DIRECTOR	ADDRESS '	N.W. 25a. REC'D BY REGIST		
	W UI CILAMPER !	400 CHAPIN ST.	18,000	c 1007 OCCU	arles Jung

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remaye carbon papers. Pages 1 and should be filed with the State Dept. of Health priar to burial, crematian, or remaval, and in any event, within 72 haurs after deat Page 4 may be retained by the haspital ar attending physician.

VR A15 (4) 25M 1/67

 MARYLAND DEPARTMENT OF HEALTH

The same of the Telefavely II constructed in the second section of Charle Clomer vloughntis (Proble) Diabetes Mellitus - Palmonary Takeralises amoll Egant a man a man a The collection of the collecti 100 Tolor 100 There are the 100 Tolor 100 Tolo THE STEEL ST. THE STEEL ST. THE ST. AND TH

11205MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11206 after-death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY b. COUNTY Montgomery MARYLAND Maryland by a Pages b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda (rural) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) remove corbon papers. Pagen on event, within 72 hours requires that the death certificate be executed within 24 hours 2 days Chevy Chase .⊆ d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENC ON A FARM? Naval Hospital 4608 Chevy Chase Blvd, NO TO YES NAME OF First Middle 4 DATE Month Dov Year DECEASED Thomas Joseph HICKEY (Type or print) DEATH AUGUST S. SEX 6. COLOR OR RACE IF UNDER 1 YEAR 7. MARRIED 9. AGE (In years IF UNDER 24 HRS B. DATE OF BIRTH NEVER MARRIED birthday) Months Davs Male March 7, 1902 Cauc. WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT physician c during post of working life, even if retired) INDUSTRY St. Louis, Missouri USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremotion, or remaval, attending phy permit. Then Jeremiah Hickey Ann Lawton 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address Chevy Chase Maryland (Yes, no, or unknown) (If yes give wor or dates of service) Yes 489 34 4666 Mrs. Helen W. Hickey, 4608 Chevy Chase Blvd 1925-1948 signed by the obviol-transit per 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c). INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) Chronic Interstitial Pulmonary Fibrosis by the hospital or ottending physician. DUE TO burial, Conditions, if ony, which gove (b) rise to immediate couse (o), DUE TO stoting the underlying couse PHYSICIAN: The law last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) etoched for use Dept. of Health p Arteriosclerotic Cardiovascular Disease YES X NO TO FUNERAL DIRECTOR: After this certificate 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c. TIME OF INJURY Month, Dov. Yeor 20d. INJURY OCCURRED (City or town) 20e. PLACE OF INJURY (Home, form, (County) (Stote) Hour o.m foctory, street, office bldg., etc.) Not While ot work at work 21. I certify that (4) (this bespital attended the deceased fram August 28, 19 67, to August 30, 19 67, that (2) (we) last be retained saw the deceased alive on August 30 1967, and that death accurred at 200AM, from causes and on the date stated above. 22o. SIGNATURE 22b. DATE SIGNED August 30. 1967 M.D. DIRECTOR PHYS director, page shauld be filed 22d. ADDRESS 22c. PHYSICIAN'S TO HOSPITAL NAME (Type) LT J. B. EMERY USN Naval Hospital, Bethesda, Md. 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) (County) 9-1-1967 Arlington, National Arlington, Virginia 24. FUNERAL DIRECTOR Joseph Gawler & Sons ADDRESS 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 Charles. 5130 Wisconsin Ave. . N.W. Washington, D.C. DATE

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11207

11206

FOR STATE

HEALTH DEPT.

portment of

2, ond 3 to P.M3. Page

in pencil in Item 18. Give Pages 1,

This certificate should be executed within 24 hours ofter death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

I. PLACE OF DEATH				2. USUAL RESIDENCE	(Where deceosed liv		esidence befor	re odmission)
o. COUNTY	NTGOMERY		MARYLAND	O. STATE MARY	LAND	b. COUNTY	ONTGOM	ERY
b. CITY OR TOWN	(If autside corporate limit	s,	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If	outside corparate lin	nits, write RURAL or	nd give neores	st town)
write RURAL or	KRXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	Olney		SILV	ER SPRING	3		15-1
	ITAL OR INSTITUTION (If no		ve street address)	d. STREET ADDRESS			T	e. IS RESIDENCE
MONT	GOMERY GENE	RAL Hos	PITAL D.O.A.	2721	NORBECK	Rp.		ON A FARM? YES NO
3. NAME OF		rst	Middle	Last	4 DATE	Month	Doy	
DECEASED (Type or print)		YNE	ELBERT	HOLLAND	OF DEATH	8	17	19 67
S. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGI		INDER 1 YEAR nths Doys	Hours Min.
MALE	WHITE	WIDOWED [DIVORCED	5/18/60	103	yrs.	illiis Doys	TIOUIS MINI.
	N (Give kind of work done		D OF BUSINESS OR	11. BIRTHPLACE (Sto	te or foreign country	'}	12. CITIZEN OF	F WHAT
during most of working	CHILD	IND	USTRY	YORK,	PENNSYLVA	ANIA	COUNTRY?	S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDER	NAME			
	ALVIN J.	HOLLAND		MELV	INA RAFFE	ENBERGER		
	/ER IN U.S. ARMED FORCES?	16. SC	OCIAL SECURITY NO. 17	. INFORMANT		Address		
	(If yes give wor or dates on No		None	SISTER AND	MOTHER	SAF	1E	
1B. CAUSE OF I	DEATH (Enter only one cou	use per line for (o), (b), and (c))	84	0	•		IERVAL BETWEEN
PART I. DE	ATH WAS CAUSED BY: IMMEDIATE CAUSE	(0)	ultiple	yeren	ie In	jurie	1	TOLI AND DEATH
812	7 DUE	10 >	0 00-	1 1-	1	0 8	0 11	11
Conditions, if on	y, which gove	(b) 100	luding	pracu	lived	31	ul	
stoting the und		10 /	+ 0	the of	111	1-01	2 -	0
last.)	(c) All	e lo au	lo seri	Ring	dece	are	V,
PART II. OTHER	SIGNIFICANT CONDITIONS O	ONTRIBUTING TO	DEATH BUT NOT RELATED T	O THE TERMINAL DISEASE C	ONDITION GIVEN IN	PART 1(o)	19.	WAS AUTOPSY PERFORMED?
ST.							١ ١	YES NO
200. EXTERNAL (PRIMARY) OF C	CAUSE WAS ONTRIBUTING (*)	20b DESC	CRIBE HOW INJURY OCCURRE	D. (Enter noture of injury i	in Port Lor Part II o	Cand	Luca	es.
		at	B O	hannin	a car	in fre	nt of	heme
20c. TIME OF IN	JURY Month, Doy, Yeor	20d. INJ While		PLACE OF INJURY (Home, for	Cit	y or town ?	(County)	(Stote)
3	8-17 19.	67 While of work	Not While ot work	Street	Allren	pring	negn	e Ma
21. I certi	ify that I took charg		ains described abave,	held an Autapsy	, Inspection	Inguiry	and	d in my apinio
death resu	Ited from: Natur	al causes 🗌	, Accident S	uicide 🔲, Hamicia	de 🔲 , Undet	ermined mann	er 🗋 0	
ACTUAL	11 00	1	// /	CHIEF MEDIC	AL EXAMINER XX			00 0475 00000
SIGNATURE	Nelde	4/11	ceap	M.D.	EDICAL EXAMINER		1.	22. DATE SIGNED
EXAMINER'S NAME (Type)	BELDEN R.	REAP, M	.D.	1,15	CAL EXAMINER OF CO	Junty) 87	17/	1967
230. BURIAL, CREMAT		IEREOF	23c. NAME OF CEMETERY	OR CREMATORY	23d. LOCATIO	ON (City or Town)	(County	y) (Stote)
Burial Speci	(Y) 8/27/6	67	Gate of He	aven	Silver	Spring	, Md.	
		Y-4-	-1331 Rocky	2So. RE	C'D BY REGISTRAR	CY 25b. REGISTE	AR'S SIGNATU	moge
.Joon wife			, Maryland	TITE PIKE A	06 4 1 18	101	6	7 0
	4,0,	Maria Kalkala da Ar	The state of the s			7		

VR A15ME 6M 1/67

the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form

necessory, please execute the certificate, writing the word "pending"

TO DEPUTY MEDICAL EXAMINER:

TO FUNERAL DIRECTOR: Poge 3 should be used as a burial-transit permit. File pages 1 and 2 with PHealth prior to buriol, cremation, or removal, and in any event within 72 hours ofter death

5 may be retained for your files.

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	Man Table 1 1			

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11208 11207 CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) o. COUNTY o. STATE b. COUNTY MARYLAND c. LENGTH OF STAY IN 16 ite RURAL and give nearest tawn) O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs Page 4 may be retained by the haspital ar attending physician. HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? hin 72 YES NO [3. NAME OF Middle First 4. DATE Day Year DECEASED (Type or print) DEATH 50 S. SEX 9. AGE (In years 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HR NEVER MARRIED 30ve lost birthday) Months Hours WIDOWED DIVORCED and g 10o. USUAL OCCUPATION (Give kind of work done during most of working life, every tretired) 1Db. KIND OF BUSINESS OR BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT INDUSTRY 13. FATHER'S NAME 14. MOTHER'S-MAIDEN NAME remayal, WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMAN (Yes, no, or unknown) (If yes give wor or dotes of service) 10 18. CAUSE OF DEATH (Enter only one couse per line (b) (b), ond (c).) PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-transit IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stating the underlying couse as the certificate has been last. WAS AUTOPS' PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) Health p NO 2Do. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Yeor 2Dd INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While ot work 21. I certify that (I) (this haspital) attended the deceased fram. M, fram causes and an the date stated abave. TO FUNERAL DIRECTOR: saw the deceased alive an 196 , and that death accurred at 22o. SIGNATURE MED. STAFF DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN' NAME (Type)

23c. NAME OF CEMETERY OR CREMATORY

DATE

23d LOCATION (City or Town)

(County)

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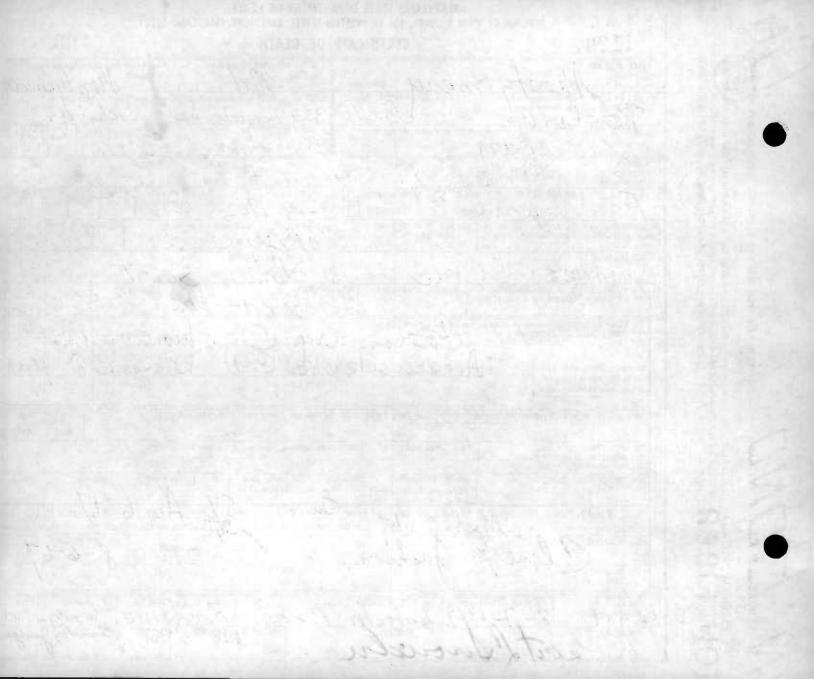
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23o. BURIAL, CREMATION,

24. FUNERAL DIRECTOR

REMOVAL (Specify)

23b. DATE THEREOF



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11208 11209 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. 1. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. county ontgomery b. COUNTY Montgomery o. SIAIE Haryland MARYIAND c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b write RURAL and give nearest town) Thr. Edismid. Silver Spring Olney d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? 9/115 Crosby Rd. Montgomery General Hospital 8. Give Pages NO2 This certificate should be executed within 24 hours after death. 3. NAME OF Middle Last 4. DATE Month Year DECEASED 1967 Hoy, Jr. (Type or print) Joseph DEATH Edward S SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH (In years birthdoy) Months last Hours WIDOWED DIVORCED white male e, writing the word "pending" in pencil in Item 1 forwarded to the Chief Medical Examiner's Office and 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Washington, D.C. Gov 1t. Lawver 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Katherine Woersdorfer File Edwa rd J. IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Olney, Md. (Yes, no, or unknown) (If yes give wor or dotes of service) event within Medical Records of Montg. General Hospt. 220-12-2520 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY Gastric Content spiration. writing the word DUF TO Hemorrhage, esophageal varies, massive Conditions, if ony, which gove rise to immediate couse (a). stoting the underlying couse 4 ears puo WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? metamor shosil YES 🔀 NO 4 should be 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) PRIMARY Or CONTRIBUTING 0 CAUSE OF DEATH cremotion, 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year factory, street, office bldg., etc.) Not While ot work ot work 21. I certify that I taak charge af the remains described above, held an Autapsy (Inspection), Inquiry XI. and in my apinian Natural causes X, Accident , Suicide , Hamicide . director. death resulted fram: Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER prior SIGNATURE FUNERAL the funerol DEPUTY MEDICAL EXAMINER **EXAMINER'S** Health John G. Ball Address (Street, city, town, or county) NAME (Type) 23b. DATE THEREOF 1967 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION, (County) (Stote) 0 REMOVAL (Specify) Gate of Heaven Cemetery Silver Spring, Maryland Cuts King ADDIS 4 Ga. Avenue 250. RECD BY REGISTRAR BOT VR A15ME (Juneral Home Silver Spring, wwwhreu

EUSI many the transfer of the first the second of N. I. S. Berning and March Street, Commission of the Street, Commission of the Commi we were the commence of the co THE WALL OF THE PARTY OF THE PA the state of the s

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11203 CERTIFICATE OF DEATH 11216 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE MARYLAND c. LENGTH OF STAY IN 1b outside corporote li ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hou d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) hin 72 filled 70 NO U carbon NAME OF Middle 4. DATE Year compretely DECEASED (Type or print) DEATH 19 6 S. SEX B. DATE OF BIRTH AGE (In years lost birthdoy) 6. COLOR OR RACE MARRIED IF UNDER 1 YEAR NEVER MARRIED Months Hours WIDOWED DIVORCED 4-23-10 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Mary Susan Ratlieff WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) 213-38-2684 Horry IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) by the haspital ar attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUF TO stoting the underlying couse has been lost. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) PERFORMED? 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or fown) (Stote) 20c. TIME OF INJURY Month, Doy, Year (County) Hour 'o.m. foctory, street, office bldg., etc.) While Not While ot work at work 21. I certify that (I) (this hospital) attended the deceased from_ that (1) (we) las 26 196 Z, and that death accurred at 5 M, fram auses and an the dote stated abave saw the deceased alive on Clus. TO FUNERAL DIRECTOR: 22b. DATE SIGNED 220. SIGNATURE ATTENDING M.D. DIRECTOR PHYS. PHYS. 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) G. Bowditch Hunter, Rockville, Md. 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, (County) (State) Burial (Specify) Aug. 30.1967 Damascus Meth. Damascus, Md. 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADDRESS VR A15 (4) 25M 1/67 Olin L. Molesworth, Damascus, Md. 1967 DAUG 29

Therefore M. marchen C Mex To me Delegan. 3 3 ha Tucherde 929 Maple and 4-28-10 37 213.38.2684 Herry & Huddle Carrier. 以及其他的特殊。 1000年 The second second Thought to the day, which AM . o. . it was no THE LOCAL PROPERTY OF THE PARTY Dis . solution . Office of art.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11211 FOR STATE HEALTH DEPT. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY any delay is, 2, and 3 ta Montgonger Montgomera P.M.3. Page rith the State Department of b. CITY OR TOWN (If outside corporate limits, LENGTH OF STAY IN 1b autside carporate limits, write RURAL and give nearest tawn) write RURAL and give nearest town DETWOOD. JET TRESCIE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Page 4 should be farwarded to the Chief Medical Examiner's Office along with farm 1000 Cynthia Lane NO D in Item 18. Give Pages This certificate shauld be executed within 24 haurs after death. 3. NAME OF Middle 4 DATE First Month Year DECEASED OF DEATH (Type or print) 217/2 S SEX 6. COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH last birthdoy) DIVORCED WIDOWED permit. File pages 1 and 2 event within 72 hours after deat 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, eyen if retired) **INDUSTRY** COUNTRY? Woshington 14. MOTHER'S MAIDEN NAME in pencil 13. FATHER'S NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service "pending" 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: burial-transit ONSET-AND DEATH =x52ngustien-trom Laceration of Neck IMMEDIATE CAUSE (o) writing the word DUF TO Auto Accident. any Conditions, if ony, which gove rise to immediate couse (o), ⊆ DUE TO stoting the underlying couse and be used WAS AUTOPSY PERFORMED? crematian, or remaval, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) the certificate, 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part 1 or Port II of item 18.) may be retained far yaur files. FUNERAL DIRECTOR: Page 3 shauld PRIMARY OF CONTRIBUTING CAUSE OF DEATH 20c. TIME OF INJURY Month, Doy, Yeor (City or town) factory, street, office bldg., etc.) Not While cckville Nont- Md of work please execute Inspection X Inquiry , 21. I certify that I took charge af the remains described above, held an Autopsy [], and in my opinian the funeral director. death resulted fram: Notural causes . Accident 📉 Suicide . Homicide Undetermined monner CHIEF MEDICAL EXAMINER **ACTUAL** 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER Health priar SIGNATURE DEPUTY MEDICAL EXAMINER **EXAMINER'S** NAME (Type) Address (Street, city, town, or county) BURIAL CREMATION DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) 50 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR VR A 15ME (5Y 6M 1/67

AND THE RESIDENCE OF THE PARTY 4

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH death. The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission). o. COUNTY o. STATE b. COUNTY STCHESTEE MARYLAND c. LENGTH OF STAY IN 15 outside corporate limits, write RURAL and give nearest town) NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street orderest d. STREET ADDRESS IS RESIDENCE ON A FARM? filled NO X nt, within YES NAME OF Middle 4. DATE drban Month, Year Doy campletely DECEASED (Type or print) 1960 DEATH 77 9. AGE (IN NEVER MARRIED DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED remave and in ony ev birthdoy) Months Dovs Hours WIDOWED DIVORCED and USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) attending physician opermit. Then please during most of working life, eyep if retired) INDUSTRY COUNTRY? tired-Housewi FATHER'S NAME 14. MOTHER'S MAIDEN NAME signed by the attending physi burial-transit permit. Then pl burial, cremation, ar remaval, UNENOWA WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT no, or unknown) (If yes give wor or dotes of service CAUSE OF DEATH (Enter only one couse per lipe, for (o), (b), and (c). INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o' be retained by the haspital ar attending physician. 6 month Conditions, if ony, which gove rise to immediate couse (o), DUE TO tar use as the k i Health priar ta b stoting the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPSY PERFORMED? NO YES certificate 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) detached for the detaction of the detact OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. factory, street, office bldg., etc.) Not While of work TO FUNERAL DIRECTOR: After 21. I certify that (1) (this haspital) attended the deceased fram 19 6 That (1) (we) last directar, page 3 shauld shauld be filed with the and that death occurred at & AM, from causes and on the date stated above. sow the deceosed olive on 226. SIGNATURE 22b. DATE SIGNED **ATTENDING** M.D. DIRECTOR PHYS PHYS. elyamon Page 4 may 22c. PHYSICUM'S NAME (Type) 22d. ADDRESS Benjamin Isaacson BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify)
Burial 8-23-1967 National Memorial ark Falls Church Va. 24. FUNERAL DIRECTOR **ADDRESS** 25o. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 Charles Goldberg Funeral Home 4217 9th St..

F MICHTEONERY CONTRACTOR Taken Tack Sugardilling Monte Vernan Miss with Similar man His mother of for Forth E. Soften But I Mount - August - 20 Francie W. Co. 100 X 100 11 3-11-11 37 4/25/2 Granting of the property of the state of and the first teach teacher the the should have TOTAL SECTION OF THE PARTY OF T

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11212 11213 CERTIFICATE OF DEATH and etely filled in by the funeral arban papers. Pages I and t, within,72 haurs after deat PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PHYSICIAN: The law requires that the death certificate be executed within 24 hours after deat o. COUNTY Montgomery o. STATE Maryland b. COUNTY MARYLAND Montgomery c. CITY OR TOWN (If autside carporote limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 1b write RURAL and give nearest town) Cabin John e. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM? 7629 Cabin Road 7629 Cabin Road YES NO 3. NAME OF 4. DATE First Middle Month Lost Dov Year DECEASED DONALD HINT IGLEHART AUGUST DEATH 14 19 67 Or (Type or print IF UNDER 1 YEAR IF UNDER 24 HRS DATE OF BIRTH 9. AGE (In years S. SEX 6. COLOR OR RACE 7. MARRIED 5 **NEVER MARRIED** remave lost birthdoy) Months Dovs Hours Male Caucasian 10/4/03 WIDOWED DIVORCED 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired)

Architect COUNTRY? INDUSTRY physician Architectural Washington, D. C.
14. MOTHER'S MAIDEN NAME TISA 13. FATHER'S NAME crematian, or remayal, Thomas G. Iglehart Olga Ulrich 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Same as permit. (Yes, no, or unknown) (If yes give wor or dates of service Mrs. Frances L. Iglehart. Wife No 216-40-9994 #2 above INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) signed by the burial-transit p PART I. DEATH WAS CAUSED BY ONSET AND DEATH ARREST IMMEDIATE CAUSE (o) men by the hospital ar attending physician. DUF TO burial, c INFARCTION MYDCARO. Conditions, if ony, which gove rise to immediate couse (o), DHE TO stating the underlying couse SCIEROSIS CORUNARY WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES NO certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) factory, street, office bldg., etc.) Hour 'o.m. While Not While ot work OR ATTENDING 19 ATE, 19_, that (1) [we) last 21. I certify that (1) (this haspital) attended the deceased fram. TO HOSPITAL OR ATTENDII
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TO FUNERAL DIRECTOR: Aft saw the deceased alive on 10 AUG 1967, and that death occurred at 8 M. M. fram causes and an the date stated obove. 22a. SIGNATURE 22b. DATE SIGNED ATTENDING directar, page 3 should be filed v M.D. DIRECTOR PHYS PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 24Th. St. N.W. Washington, D.C. THOMPSON 703 DR. CHARLES W. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION (County) REMOVAL (Specify) Rock Creek Cemetery Washington. Burial 25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Melanes VR A15 (4) Joseph Gawler's Sons, Inc., Wash., D. C. 25M 1/67

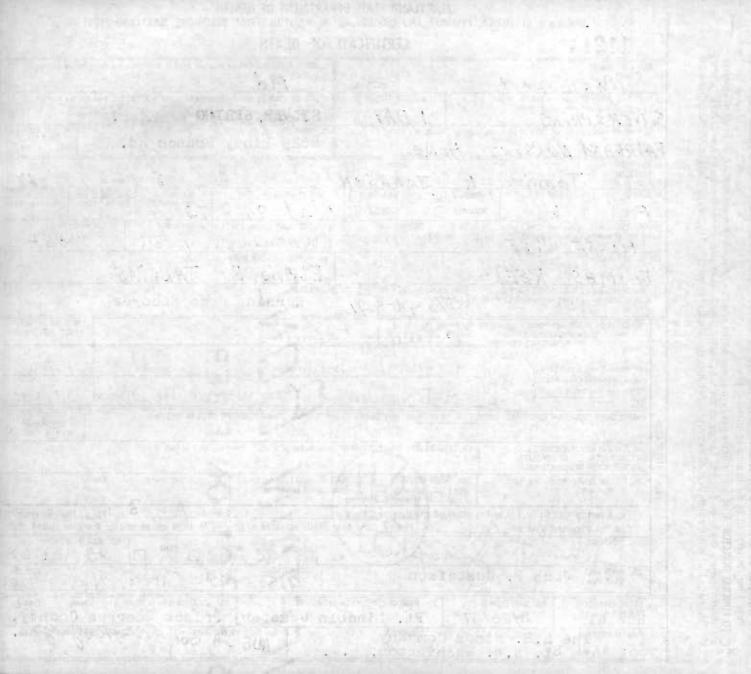
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11213 CERTIFICATE OF DEATH PLACE OF OEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY Maryland Carrol1 MARYLAND OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after b. CITY OR TOWN (If autside corparate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corparate limits, write RURAL and give negrest tawn) write RURAL and give nearest tawn) odn dapers. Pag. ldav Sykesville. Olney. Md d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? ed 69 NO K Montgomery General Hospital YES Box 244 Rt#1 NAME OF Middle Last 4. OATE Manth Year Day DECEASEO 8 event, 19 67 (Type or print) **OEATH** Jenkins Ressie IF UNDER 1 YEAR S. SEX 9. AGE (In years IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** B. OATE OF BIRTH remove last birthdoy) Months and in any WIDOWED DIVORCED 1-9-95 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired)

Housewife COUNTRY? INDUSTRY Maryland attending physic permit. Then ple ian, ar removal, c 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Maryann Hughes Q Sam Ridgely 15. WAS OECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknawn) (If yes give war ar dates of service 17. INFORMANT 16. SOCIAL SECURITY NO. permit. H burial, crematian, 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
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MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution; Residence before admission) o. COUNTY COUNTY ontgome **MARYLAND** pages 1 and 2 with the State Department PM3 write RURAL and give nearest town d. STREET ADDRESS Takoma e IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8402 26 NAME OF DATE DECEASED OF DEATH 1967 9. AGE (In years S. SEX IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED lost birthdoy) 6 3 yrs. Months certificate shauld be executed within 24 haurs of WIDOWED event within 72 hours after death 10b, KIND OF BUSINESS OR, 10o. USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT 11. BIRTHPLACE (State or foreign country) during most of working life, even if retired) ward "pending" in pencil in the Chief Medical Examiner's 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME noon WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO Address (Yes, no, or unknown) (If yes give wor or dotes of service) 18. CAUSE OF DEATH (Enter only one couse per line PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-transit ONSET AND DEATH IMMEDIATE CAUSE (o) DUF TO in any Conditions, if ony, which gove farwarded to rise to immediate couse (a), DUE TO stoting the underlying couse and and WAS AUTOPS'
PERFORMED? NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) remayal, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Trijury in Port I or Port II of item 18.) 3 shauld PRIMARY Or CONTRIBUTING CAUSE OF DEATH. burial, crematian, 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) please execute the foctory, street, office bldg., etc.) Hour o.m. Not While may be retained far your FUNERAL DIRECTOR: Page ot work ot work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection X and in my opinian Suicide Natural causes death resulted from. Hamicide Undetermined manner the funeral director. CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED 5 may be refr TO FUNERAL DI Health priar t ASSISTANT MEDICAL EXAMINER SIGNATURE NAME (Type) 23c. NAME OF CEMERED OR CHEMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (Stote) Burial (Specify) 7, 1967 Ft Lincoln Cemetery Colmar Manor Pro Geo Md. 24. FUNERAL DIRECTOR VR A15ME (5) F. Gasch's Sons Hyattsville, Md. 6M 1/67

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certificate be ig physician of Then please imaval, and ii	13.	ing most of working life, even if retired) INDUSTRY FATHER'S NAME SCAR Thomas		Struthers, Oh 14. MOTHER'S MAIDEN NAME Hattie	io	COUNTRY? USA
FO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death Page 4 may be retained by the haspital ar attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral directar, page 3 shauld be detached far use as the burial-transit permit. Then please remave corban papers. Pages 1 and 2 shauld be filed with the State Dept. af Health priar ta burial, crematian, ar remaval, and in any event, within 22 haurs after death	(Y	18. CAUSE OF DEATH (Enter only one couse per line for (o), (b) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO	0-3255 Mrs	Harriet Wood	Washington -5024 Easter	, DC D AVE., NE, INTERVAL BETWEEN ONSET AND DEATH
OR ATTENDING PHYSICIAN: The law requires the be retained by the haspital ar attending physician. DIRECTOR: After this certificate has been signed by 18 3 shauld be detached far use as the burial-trared with the State Dept. af Health priar ta burial, cree	CATION	rise to immediate couse (a), stating the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEAT	H BUT NOT RELATED TO TH	HE TERMINAL DISEASE CONDITION		19. WAS AUTOPSY PERFORMED? YES \(\begin{array}{c} NO \(\begin{array}{c} \begin{array}{c} \ext{VS} \\
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D HOSPITAL OR ATTENDIPOR 4 may be retained by FUNERAL DIRECTOR: Affidirector, page 3 shauld by shauld be filed with the St		21. I certify that (I) (this haspital) attended the saw the deceased alive an 220. SIGNATURE	e deceased fram_A _19 6 7, and that 	ATTENDINGMED.	STAFF S	, 19 7, that (1) (we) last an the date stated above 22b. DATE SIGNED
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VR A15 (4) 20 M 1/66	24	FUNERAL PRESTOR	3015 12th Washington,	St., C. DATE AUG		RAR'S SIGNATURE

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	done during most of working life, even if retired)	11.50
1	13. FATHER'S NAME	00.0
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	21. I certify that (I) (this hospital) attended the deceased from	, 19 ⁰ , that (I) (we) la
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	228. SIGNATURE ATTENDING MED. STAFF	22b. DATE
	M.D. PHYS. DIRECTOR PHYS.	8-11-6
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2	236. BURIAL, CREMATION, 236. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY / 23d. LOCATION (CITY	, town or county) (State)
	BEMOVAL (Specify) 8/13/67 King David Hom. Garden Falls Ch	urch, Va.
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MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11213 CERTIFICATE OF DEATH transit permit. Then pleose remove corbon papers. Pages 1 and 2 cremation, or removal, ond in ony event, within 72 hours after death. and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY a. STATE b. COUNTY MARYLAND MONTGOMERZ MARIJLAND. MONT COMER c. CITY OR TOWN (If autside carparate limits, write RURAL and give neorest tawn) b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 16 write RURAL and give nearest town) WHEATON WHEATON d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? and completely filled in YES NO > NAME OF Middle Last 4. DATE Month Day Year DECEASED 2 ALFRED 19 (Type or print) DEATH requires that the death certificate be executed IF UNDER 1 YEAR IF UNDER 24 HRS SEX 9. AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthdoy) Months Days Haurs WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Caunty & State, ar foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? physicion NEW YORK RETIRED 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME ORRIS 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, na, or wiknawn) (If yes give wor ar dotes of service) 25-GA AUE. SSPEL INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), ONSET AND DEATH hos been signed by the se os the burial-transit PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) be retained by the hospital or ottending physician. DUE TO burial, Conditions, if any, which gove rise to immediate cause (o). DUE TO os the prior to b stoting the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING/10 DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(0) WAS AUTOPSY PERFORMED? for use with the State Dept. of Health NO O FUNERAL DIRECTOR: After this certificate 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year Hour a.m. factory, street, affice bldg., etc.) ot work should be 21. I certify that (1) (this hospital) attended the deceased fram. z, 1942, that (I) (we) last and that death accurred at M, fram causes and an the date stated above 19 07 saw the deceased alive an. 22b. DATE SIGNED 22a. SIGNATURE DIRECTOR PHYS. M.D. director, page should be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) ASD 23b, DATE THEREOF 23c. NAME OF CEMETERY OR CREMAJORY 23u. BURIAL, CREMATION, LOCATION (City or Town) (County) 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 1967

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CEDTIFICATE OF DEATH

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/					Wurtsmith,			USA
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	D. Keener				Emma Jes	an Rose		
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N.A	(If yes give war ar dates af	201 AICE		Mr.	George D.	Keener, Box	144 Her	old Route
	EATH (Enter anly one cause	per line far	(a), (b), and (c).)					INTERVAL BETWEEN
PART I. DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE (c	CON	GENITAL HE	ART	DISEASE			ONSET AND DEATH
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OR CONTRIBUTING	CAUSE OF DEATH	200. DE.	SCRIBE HOW INJOKT OCC	NKLD.	ciner notate of injury in	ruis i di ruis ii di nein 16.)		
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sow the d	eceosed olive onA	ugust	25 19 67 , on	d thot	deoth occurred of	M, from couses		
22a. SIGNATURE					ATTENDING -	MED. STAFF	and .	TE SIGNED
6		wh	- 246	M.D	. PHYS. L	DIRECTOR L PHYS.	Aug.	25., 1967
22c. PHYSICIAN'S NAME (Type			9		22d. ADDRESS	M		
						spital, Bether		
23a. BURIAL, CREMATIN	4		23c. NAME OF CEMETE			23d. LOCATION (City or T	,	County) (Stote)
Burlat-t	ransit 8-2		Family Co	met		Sutton,		
24. FUNERAL DIRECTO	R Robert A.	Pumphr	ey ADDRESS				EGISTRAR'S SIG	
Funeral Ho	ome, 7557 Wi	sconsi	n Ave., Bet	hes	da. Md AUG	28 1001 100	liarles	Judge

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove forban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any eventuality 72 hours after dept. VR A15 (4) 25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours after death.

Page 4 moy be retained by the hospital or ottending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11222 the death certificate be executed within 24 hours after death hin 72 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH o. COUNTY b. COUNTY o. STATE MARYLAND montgomer montoonery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 1b RURAL and give neorest town d. STREET ADDRESS e. IS RESIDEN campletely filled in papers. d. NAME OF HOSPITAL OR INSTITUTION (If no an hospital, give street address) ON A FARM? 2230 YES □ NO K DATE Month NAME OF Middle Doy Year DECEASED event, DEATH 50 (Type or print) SEX AGE (In years 7. MARRIED birthdoy) remoye lost Months Dovs Hours WIDOWED DIVORCED ond in on and 1Db. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 1Do. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) COUNTRY? during most of working life, even if retired) INDUSTRY physician (hurrely MOTHER'S MAIDEN NAME 13. FATHER'S NAME or removal, 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. md permit. (Yes, no, or unknown) (If yes give wor or dotes of service) 05-708 cremation, CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) buriol-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) signed by DUF TO buriol, (Conditions, if ony, which gove rise to immediate couse (o). DHF TO stoting the underlying couse Poge 4 moy be retained by the hospital or attending peen detached for use os the te Dept. of Health prior to lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) TO FUNERAL DIRECTOR: After this certificate has NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) with the Stote Dept. 20d. INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. foctory, street, office bldg., etc.) Not While ot work ot work pe 21. I certify that (1) (this haspital) attended the deceased from Merch 20, 1967, to Lipe 1967, and that death accurred at 65 PM, from duses and an the date stated above saw the deceased alive an 22b. DATE SIGNED 22o. SIGNATURE **ATTENDING** DIRECTOR director, page 3 should be filed v M.D. PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) LOCATION (City or Town) 23o. BURIAL, CREMATION, REMOVAL (Specify) (Stote) DATE THEREOF 23d. (County) REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11223 11222 MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY Page 50 MONTGOMERY MARYLAND MARYLAND deloy Stote Deportment b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) and P.M3 Olney DOA d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS drm Give Pages NO te Montgomery General Hospital YES 🗍 be executed within 24 hours after death. olong with NAME OF Middle Last 4. DATE Manth Day Year DECEASED (Type or print) Charles Nicholson Kendall DEATH SEX 7. MARRIED 6. COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 8. DATE OF BIRTH NEVER MARRIED Item 18. last birthday) Manths Days Hours Min WIDOWED DIVOR CED 8/21/01 Office (65 yrs. lond 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or fareign country) 12. CITIZEN OF WHAT during mast af warking life, even if retired) INDUSTRY COUNTRY? d "pending" in pencil in Chief Medical Examiner's Ithica, Ny Retailer General Store 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Franklin Kendall Mabel Crawford 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (wife & Address (Yes, na, ar unknawn) (If yes give war or dates of service within 212-34-3911 Mary P. Kendall Clarksville. Maryland 18. CAUSE OF DEATH (Enter only one couse per line for (a). INTERVAL BETWEEN burial-tronsit event ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) word This certificate should DUE TO any Conditions, if any, which gave rise ta immediate cause (a), 0 = DUE TO stoting the underlying couse and ds removol, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT/RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19 WAS AUTOPS certificate, NO pe 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) 3 should should PRIMARY CONTRIBUTING CONTRIBUTING 0 CAUSE OF DEATH. cremotion, 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or tawn) (County) (State) Hour o.m. factory, street, office bldg., etc.) DIRECTOR: Page Nat While ot wark at wark 21. I certify that I took charge of the remains described above, held on Autopsy Inspection X ond in my opinion buriol. Suicide death resulted from: Natural couses ... Accident Hamicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER prior SIGNATURE FUNERAL I Health moy EMETERY OR CREMATORY LOCATION (City or Fawn) 0 Aug.17,1967 St. Warks Highland, Md 2Sq. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15ME (5 ginbothom-Slack, Ellicott City, Md DATE 1967

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CERTIFICATE OF DEATH

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ž	RURAL and give nearest town)	00	IN 16 C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA d. STREET ADDRESS 6009 RIVER ROAD Lost 4. DATE OF DEATH P. AGE (In years lif under 1948) B. DATE OF BIRTH DO J S. AGE (In years lif under 1948) RINDUSTRY 11. BIRTHPLACE (State ar foreign cauntry) BELLEFONTAINE OHIO 14. MOTHER'S MAIDEN NAME DO J S. A 15. INFORMANT DO J SEASE 17. INFORMANT DISEASE SEVINTER Address LEROTIC HEART DISEASE CONDITION GIVEN IN PART 1(0) DISTERVAL BETWEEN ONSET AND DEATH SEVINTERVAL BETWEEN ONSET AND DEATH SEVINTER	give negresi rownj	
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5.	SEX 6. COLOR OR RACE 7. MAR	RIED NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years IF UNDER	1 YEAR IF UNDER 24 HRS.
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15	. WAS DECEASED EVER IN U. S. ARMED FORCES? 16.	SOCIAL SECURITY NO. 17. II			
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=	18. CAUSE OF DEATH [Enter only one couse per li	ine for (a) (b) and (c)]	Wally ill	PLINGER TOLLS	
	PART I. DEATH WAS CAUSED BY:	-70 00 70 70 70	Hima	- DISTART	ONSET AND DEATH
	IMMEDIATE CAUSE (o) 1118	TERIOSCLER	ONC ITEAK	I. DISEASE	SEVIYRS
	DUE TO				
	Conditions, if ony, which (b)				
	coese (o), stoting the under-				
1	lying couse last. (c)				
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AEDI	Hour a. m. 19 at wor	Not while	clory, street, office bldg., etc)	
1			2 20/7 . AL	10000 10 10 17 11 11	1
	21. I certify that I attended the decease			1645T 6 , 1967, that I	
	alive on 14 ugust 9 , 194	1.4.,., and that death	occurred at bills	M, from the causes and on the	he date stated above DATE SIGNE
	ACTUAL NITER		011 1014	ADDRESS (Street, city or town, stote)	DATE SIGNET
	SIGNATURE // CCCC		M.D. 916-1912	Dr. N. W. WASHINGT	TON OC 916161
	PHYSICIAN'S HENRY D. EC	KER M.D.			
22	REMOVAL (Specify)	22c. NAME OF CEMETERY O	R CREMATORY	22d. LOCATION (City, town, or county)	(Stote)
1	CREMATION HVQ 7, 1967	CEDAR HILL CA	CMATORY	SUITIAND, MARY	land .
23	B. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'	DARY REGISTRAR 245 REGISTRARYS SH	GNATURE OLLAR
-	Tocach Guilage Soul	IND. Woch!	WELL TO A DUTE	AUG 8 1961 7	and have

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs TO FUNERAL DIRL page 3 should be VS A15 (4) 15M 9/55

DEUNERAL DIRU.: After this certificate has been signed by the ottending physicion and campletely filled in page 3 should be acched for use as the burial-transit permit. Then please remove carbon papers. Pages 1 on the registror prior to burial, crematian, or remavol, and in ony event within 72 hours offer death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) campletely filled in by the funeral ave carban papers. Pages 1 and o. COUNTY o. STATE Jon I gomes b. COUNTY MARYLAND c. LENGTH OF STAY IN 16 b. CITY OR TOWN (If outside corporate limits, c. CITY OR JOWN (If outside corporate limits, write RURAL and give write RURAL and give nearest town) 13. 105 Kille d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? YES 🔀 NO 3. NAME OF Middle 4. OATE Doy Lost Month Year OECEASED Cornelis Kobert NE PPEZ HOUT de STERKENBUR (Type or print) DEATH IF UNDER 24 HRS S. SEX AGE (In yeors IF UNDER 6. COLOR OR RACE B. DATE OF BIRTH 7. MARRIED NEVER MARRIED lost birthdoy) Months Dovs Hours Wh WIOOWEO OIVORCED and 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT lease during most of working life, even if retired) INCUSTRY COUNTRY? DOORN NETHERLAND NETHERLANT tarmer. Relires 13. FATHER'S NAME 14. MOTHER'S MAJOEN NAME KNEPPELHOUT VAN STERKENBURG CORNELIA SCHUURBEKE 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) 1B. CAUSE OF OEATH (Enter only one couse per line for (o), (b), ond (c).) INTERVAL BETWEEN burial-transit PART I. OEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o). DUE TO stoting the underlying couse the has been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO OEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? NO X YES O FUNERAL DIRECTOR: After this certificate far 20b. DESCRIBE HOW INJURY OCCURREO. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 20c. TIME OF INJURY Month, Oov. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) (Stote) Not While foctory, street, office bldg., etc.) ot work ot work . 19 6 / that (I) (we) last 1952-10 21. I certify that (I) (this hospital) attended the deceased from_ 1967, and that death accurred at 2 4. M, fram causes and on the date stated above. saw the deceased alive an 22b. DATE SIGNED 220. SIGNATURE OIRECTOR 22d ADORESS 22c. PHYSICIAN'S NAME (Type) directar, shauld 23b, OATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23o. BURIAL, CREMATION, (County) REMOVAL (Specify) 24. FUNERAL DIRECTO VR A15 (4) DATE AUG 20 M 1/66

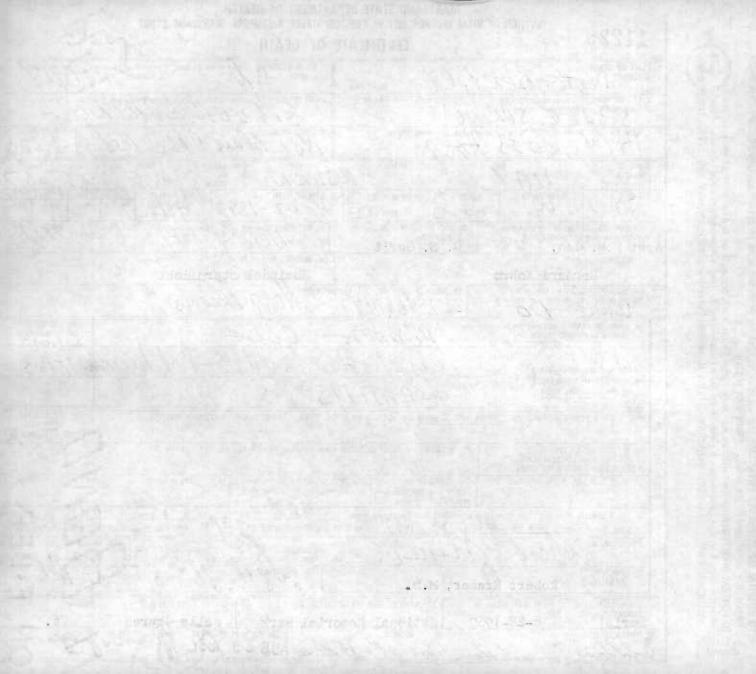
MARYLAND STATE DEPARTMENT OF HEALTH

TOTAL TERMINATION OF THE PROPERTY OF THE PROPE

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 1225 CERTIFICATE OF DEATH 11226 OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY a. STATE MARYLAND b. CITY OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) write RURAL and give neorest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 20 YES NO X NAME OF Middle 4. DATE carban Lost Day Year DECEASED (Type or print) DEATH S. SEX 6. COLOR OR RACE 7. MARRIED 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS NEVER MARRIED B. DATE OF BIRTH last birthday) Months Days ond in any WIDOWED DIVORCED and 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during mast of warking life, even if retired) INDUSTRY COUNTRY? innonATI 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME removol, 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, of unknown) (If yes give war ar dates af service crematian, 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c), INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Canditions, if any, which gave right overy (primary) rise to immediate cause (a), DUE TO stating the underlying cause Papillary serous cystaneocarcinoma) has been last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Tumor perforation of ileum with loculated purulent peritonitis. YES X NO certificote 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) by the hospital OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (State) Hour a.m. factory, street, affice bldg., etc.) While Nat While at work to 8-13-1967, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram 10-22-1900 Poge 4 moy be retoined and that death accurred at 312 A.M., fram causes and an the date stated above. saw the deceased alive an 19 67 O FUNERAL DIRECTOR: 22a, SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR director, page should be filed Old Georgetown 22d. ADDRESS 10401 22c. PHYSICIAN'S O HOSPITAL NAME (Type) RONALD. Bethesda. _Marvland 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) REMOVAL (Specify) Prince George County . Md 8-15-67 Ft. Lincoln Crematory Cremation UMPHREY, Bethesda, Maryland 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 196 DATE AUG

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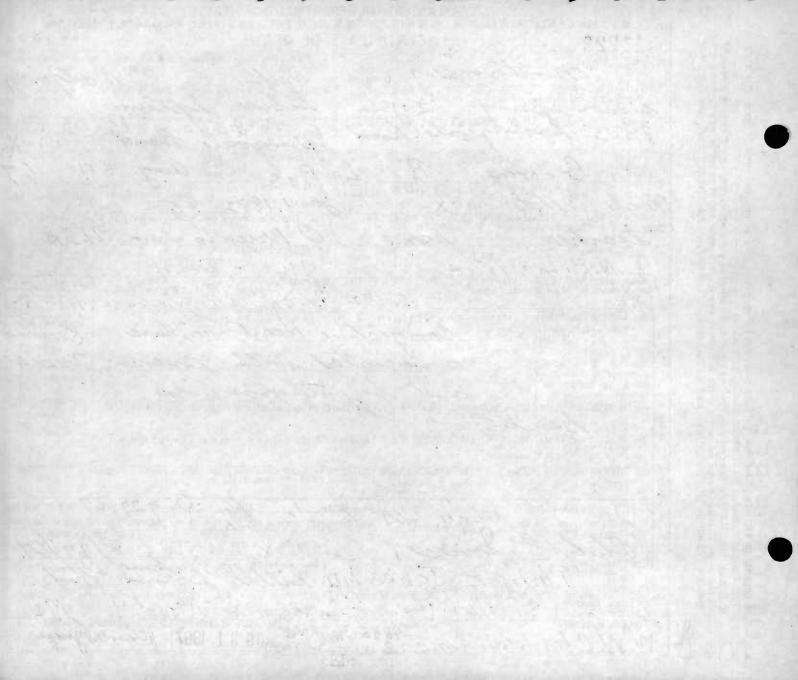
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11227 CERTIFICATE OF DEATH executed within 24 haurs after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE b COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write-RURAL and give negrest town) c. LENGTH OF STAY IN 16 c. CITY OR JOWN (If outside corporate limits, write BURAL and give nearest town) campletely filled in by the ave carban papers. Page y event, within 72 haurs at d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 3. NAME OF Middle 4. DATE Month Yeor DECEASED (Type or print) 190 DEATH campi 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX . 6. COLOR OR/RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED remave Months Doys Hours WIDOWED DIVORCED and in any and 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) INDUSTRY COUNTRY? Asst P.M. Men Govit 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or remaval, Bernard Kohrn Sheindel Sternlicht 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wonor dotes of service) 17. INFORMANT 16. SOCIAL SECURITY NO Address crematian, 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b) ond (c). INTERVAL BETWEEN signed by the burial-transit p PART I DEATH WAS CAUSED BY ONSET, AND DEATH IMMEDIATE CAUSE (o) DUF TO burial, Conditions, if ony, which gove rise to immediate couse (a). DUE TO attending stoting the underlying couse priar ta as the lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? has State Dept. of Health 0 this certificate for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) 20o. ACCIDENT WAS UNDERLYING the haspital OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While of work ot work 21. I certify that (I) (this haspital) attended the deceased from O HOSPITAL OR ATTEND Page 4 may be retained ond that death occurred at 2 P/M, fram couses and an the date stated above. DIRECTOR: saw the deceased alive on_ 1961 220. SIGNATURE 22b. DATE SIGNED **ATTENDING** STAFF M.D. DIRECTOR PHYS 22d. 22c. PHYSICIAN'S TO FUNERAL NAME (Type) Robert Kramer, M.D. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL CREMATION. (County) (Stote) REMOVAL (Specify) 8-28-1967 National Memorial Park Falls Church Buria 256. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67 196/



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE DF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY after MARYLAND c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY DR TOWN (if outside corporate limits, write RURAL and give hearest town) hours non Bapers. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, gite street address e. IS RESIDENCE ON A FARM? d. STREET AOORESS 24 within, ND IP YES within 3. NAME DE First DATE Middle Oay Last Month DECEASED 9 events Car (Type or print) ROPORD DEATH 196 executed 5. SEX 6. COLOR OR RACE AGE (In wars | IF UNDER 1 YEAR | IF UNDER 24 HRS | last birthday) | Months | Days | Hours | Min. 8. DATE OF BIRTH 9. remove 7. MARRIED NEVER MARRIED any and WIDDWED X DIVORCED yrs. = 1Da. USUAL OCCUPATION (Give kind of work done 1Db. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) sician lease and ir be during most of working life, even if retired) INDUSTRY attending physic ermit. Then plea death certificate removal. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES 17. INFORMANT 16. SDCIAL SECURITY ND. Address transit permit. (Yes, no, or unkown) | (If yes give war or dates of service) Lelton ntoomerz 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN The law requires that the ONSET AND DEATH p PART I. DEATH WAS CAUSED BY: the hospital or attending physician. IMMEDIATE CAUSE (a) signed been signed the burial-to or to burial, DUE TO Cenditions, If any, which gave rise to Immediate DUE TD cause (a), stating the underlying cause last. has 88 CERTIFICATION 19. WAS AUTDPSY PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use Health PERFORMEO? certificate ND T PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) this cerum detached for 2Db. DESCRIBE HDW INJURY DCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) (State) 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) be de State factory, street, office bldg., etc.) Hour a.m. After Id be d Not While p.m. at work at work retained should ith the 21. I certify that (I) (this hospital) attended the deceased from DIRECTOR: age 3 should lled with the and that death occurred at saw the deceased alive on M, from the causes and on the date stated above. SIGNATURE 22b. DATE SIGNED 22a. page ATTENDING MED. M.O. PHYS. DIRECTOR PHYS. 4 may HOSPITAL 22c. PHYSICIAN'S 22d. ADDRESS director, p NAME (Type) (State) BURIAL, CREMATION, 23b. DATE THEREOF 23c, NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) REMOVAL (Specify) 6600 JUTIA 25a. REC'O BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 1/65



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EXAMINER: tute the certions oge 4 should your files. Poge 3 should do agent, pri	MEDICA	2Dt. TIME OF INJURY Month, Doy, Yeor 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, foctory, street office bldg., etc.) 2Df. TIME OF INJURY Month, Doy, Yeor 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, foctory, street office bldg., etc.) Silver Spring Mont, Month, Doy, Yeor 2Dd. INJURY OCCURRED 2Dd. INJ	(Stote) g. Md.
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TO L the 5 n TO F	230	D. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETRY OR CREMATORY 23d. LOCATION (City or Town) (County) REMOVAL (Specify) Aug 7, 1967 Cedar Hill Cemetery Suitland Maryland AUDIESS ADDRESS 250 PECID BY PEGISTRAR Lash PROMINES SUPERIUM ADDRESS 250 PECID BY PEGISTRAR Lash PROMINES SUPERIUM ADDRESS	(Státe)
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11232 MEDICAL EXAMINER'S CERTIFICATE OF DEATH **FOR STATE** 11233 HEALTH, DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) COUNTY STATE b. COUNTY State Department of MARYLAND meri b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give pearest town) 010 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? alang with farm NO This certificate should be executed within 24 hours after death. NAME OF First Middle Lost DATE Dov Year DECEASED OF in Item 18 Give lan (Type or print) DEATH 19 permit. File pages I and Nwith S. SEX 7. MARRIED 9. AGE (In years IF UNDER 1 IF UNDER 24 HRS 6. COLOR OR RACE REVER MARRIED 8. DATE OF BIRTH last birthdoy) Months Dovs Hours event within 72 haurs after death. DIVORCED WIDOWED farwarded to the Chief Medical Examiner's Office 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT or foreign country) during most of working life, even if retired) a **INDUSTRY** COUNTRY? harmaci 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME in pencil 15. WAS DECEASED EVER INVLS. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) "pending" 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), one (c). INTERVAL BETWEEN burial-transit PART 1. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) writing the ward DUF TO any Conditions, if ony, which gove rise to immediate couse (a). = DUF TO Ö stoting the underlying couse and dS lost. used PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPS remaval, PERFORMED? CERTIFICATION please execute the certificate, NO pe I 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) 3 should ä PRIMARY | or CONTRIBUTING | 4 should CAUSE OF DEATH. crematian, MEDICAL 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) Hour o.m. While Not While foctory, street, office bldg., etc.) VOUL FUNERAL DIRECTOR: Page of work ot work 21. I certify that I took charge of the remains described above held on Autopsy Inspection ond in my opinion Notural couses deoth resulted from: Hamicide Undetermined monner be retained CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED prior ASSISTANT MEDICAL EXAMINER SIGNATURE funeral **EXAMINER'S** may Health fown or county) 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL CREMATION. DATE THEREOF 23d. LOCATION (City of Jown) (Stote) 0 BUR A (Specify) KING DAVID MEMORIAL CHURCHNA EARDEN 24. FUNERAL DIRECTOR ADDRESS A 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATI VR A 15ME (5) 196 6M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11233 CERTIFICATE OF DEATH 11234 requires that the deoth certificate be executed within 24 hours after deoth. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY MONTGOMERY o. STATE b. COUNTY MARYLANO VTRGTNTA completely filled in by the love corbon papers. Pages y event, within 72 hours afti c. LENGTH DE STAY IN 1b b. CITY DR TDWN (If autside corporate limits, write RURAL and give nearest tawn) c. CITY DR TOWN (If outside carporate limits, write RURAL and give nearest town) 79 days STERLING d. NAME DF HDSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? NAVAL HOSPITAL 206 FTR COURT YES NO T 3. NAME OF First Lost 4. DATE Month Oov Year DECEASED ROBERT NORMEN AUGUST (Type or print) LEWIS DEATH IF UNOER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 8. OATE OF BIRTH 9. AGE (In years 7. MARRIEO NEVER MARRIEO lost birthdoy) Months Ooys 15 MAY 1941 ond in any WIDDWED DIVORCED MALE CAUC 10o. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) **INOUSTRY** COUNTRY? Union Co. New Jerseu ottending physician permit. Then please MTT.TTARY TISA 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME or removal, NORMAN LEWIS MARTAN HOLLY 15. WAS DECEASED EVER IN U.S. ARMED FDRCES? 17. INFORMANT 16. SOCIAL SECURITY ND. Address (Yes, no. or unknown) (If yes give wor or dotes of service) YES 225-52-9712 SANDRA L. LEWIS. 206 FIR COURT STERLING 1 burial-tronsit pern burial, cremotian, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSEO BY: INTERVAL BETWEE ONSET AND DEATH HODGKINS DISEASE IMMEDIATE CAUSE (o) by the hospital or attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMEO? YES X NO 20o. ACCIDENT WAS UNDERLYING 20b. OESCRIBE HDW INJURY OCCURRED. (Enter noture of injury in Port 1 or Part II of item 18.) OR CONTRIBUTING CAUSE OF OF ATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Ooy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) **DIRECTOR:** After this Not While Hour o.m. foctory, street, office bldg., etc.) of work ot work 21. I certify that (1) (this haspital) attended the deceased fram 22 MAY , 167 , td.9 AUGUST , 167 , that (I) (we) last O HOSPITAL OR ATTEND Page 4 moy be retained saw the deceased alive an 10 AUGUST 1967, and that death accurred at 50AM, fram causes and an the date stated above. 22h OATE SIGNEO 22o. SIGNATURE X DIRECTOR PHYS. 19 AUGUST 1967 22d. ADDRESS 22c. PHYSICIAN'S TO FUNERAL NAME (Type) JOHNSON. MC. USN NAVAL HOSPITAL BETHESDA. 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY DR CREMATORY 23o. BURIAL, CREMATION, REMOVAL (Specify) ARLINGTON NATIONAL ARLINGTON 2So. REC'O BY REGISTRAR 25b. REGISTRAR'S SIGNAT 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67 3901 N. FAIRFAX DR. ARLINGTON, VA. ARLINGTON FUNERAL HOME.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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11234 **IO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and compretely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 should be filed with the State Dept. af Health priar ta burial, crematian, ar remaval, and in any event, within 72 hours after death

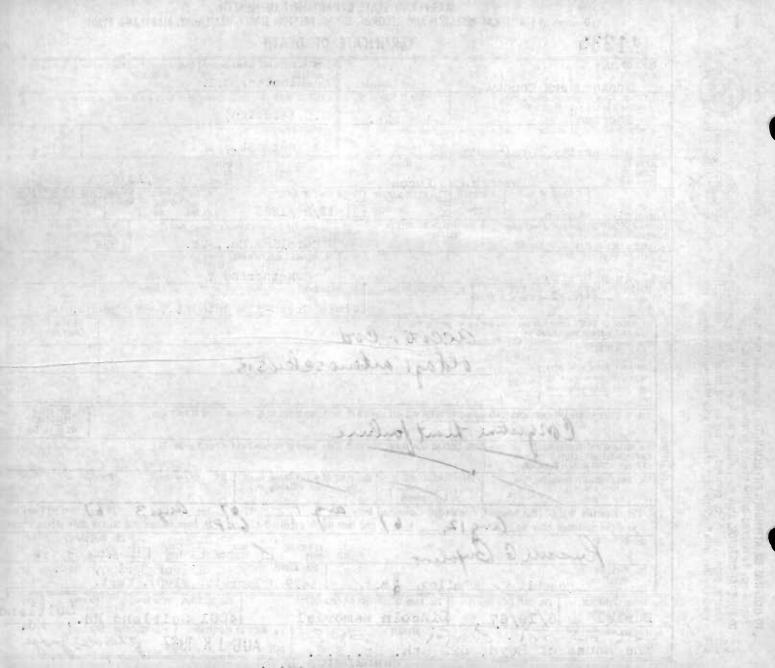
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exec**uted** within 24 haurs after death. Page 4 may be retained by the haspital ar attending physician.

VR A15 (4) 25M 1/67

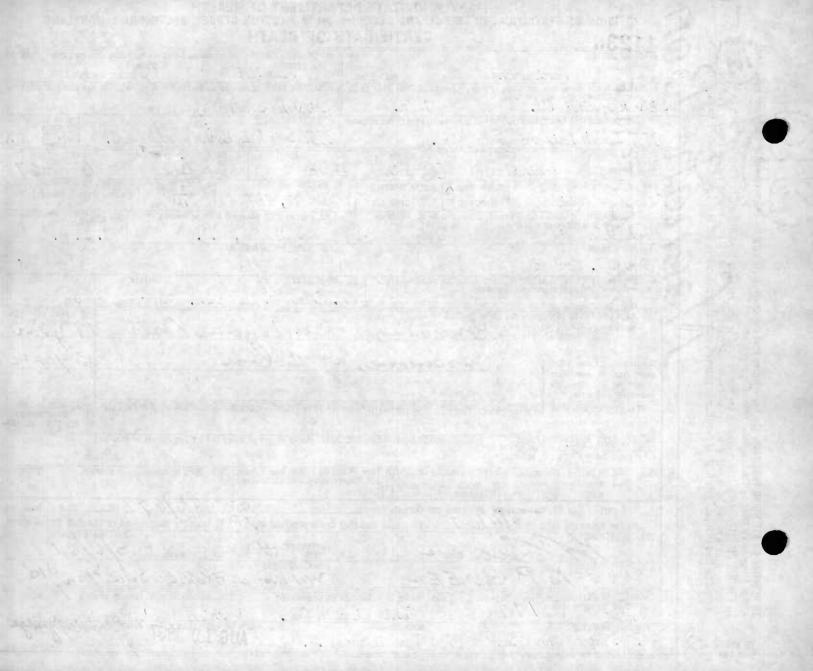
CERTIFICATE OF DEATH

	1. PLACE OF DEATH O. COUNTY MONT GOMETY MARYLAND							2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE b. COUNTY Maryland Montgomery							
	b. CITY OR TOWN (If outside corparate limits, write RURAL and give necrest town)						1b	c. CITY OR TOWN (If outside carparote limits, write RURAL and give nearest town)							
- 1	Olney DOA							Rockville /5./						1	
	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)							d. STREET ADDRESS		glish	Manor			e. IS RESIDEN ON A FARM	CE
7		Montgome	ry General	Host	ital			14007	Lone	don L	ane				D K
1	3. N	AME OF	Fi			Middle		Last		4. DATE	Mo	nth	Doy	Year	
Я	(1	Ype or print)	Thom	25		Joseph		Loftus		OF DEATH	Augu	st	28,	19 6	7
Ī	s. si	EX	6. COLOR OR RACE	7. MARRI	IED X	NEVER MARRIED		B. DATE OF BIRTH		9	. AGE (In years	IF UNDER	1 YEAR	IF UNDER 24	
4	M	lale	White	WIDOW	/ED	DIVORCED		1/27/03		U.S.	6 ost birthdoy) yrs.	Months	Doys	Hours	Min.
	10o.	USUAL OCCUPATION	(Give kind of work done	106	10b. KIND OF BUSINESS OR INDUSTRY GOVIT			11. BIRTHPLACE (Co	ounty &	Stote, or for	reign country)		TIZEN OF		
	F	most of working l	der	F	rint	ing Offi	ce	Kansas	S			(0	UNTRY?		
1	13.	FATHER'S NAME				17 11 19		14. MOTHER'S MAI		AME					
1	P	atrick I	oftus					Nellie	e Ma	aher					
	15.	WAS DECEASED EVE	R IN U.S. ARMED FORCES? (If yes give wor or dotes o		16. SOCIAL	SECURITY NO.	17. 1	NFORMANT			Add	ress			
		yes	(ir yes give wor or dotes o	service			1	Medical Records							
Ī	T	18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)						INTERVAL BETWEEN							
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction ONSET AND DEATH OF THE PROPERTY OF THE PARTY OF THE PART									hrs.	TH			
		4201	DUE												
		Conditions, if ony,	which gove	(b)	Arte	rioscler	otio	cardiova	asci	ular	disease				
		rise to immediate couse (a), stating the underlying couse DUE TO													
		lost.)	(c)											
	Z	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED?										Y			
4	A E												Y		
	EE								iry in Po	art I or Por	t II of item 18.)				
	MEDICAL	20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e.						LACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote)							
	ME	Hour o.m. p.m. While of work													
		21. I certify that (I) (this haspital) attended the deceased from January , 19.60 .ptg August 167 , that (I) (we) last													
	-	saw the deceased alive an 8/28 1967, and that death accurred an 2:30 M, fram causes and an the date stated an 220. SIGNATURE 22b. DATE SIGNED									ibuve				
		And Dogwey M.						.D. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. B/28/67							
		22c. PHYSICIAN'S NAME (Type)	A. D. Bon	ifant	, М.	D.		22d. ADDRESS Medica:		enter	, Sandy	Sprin	g, N	laryla	nd
1	23o.	BURIAL, CREMATIO	N, 23b. DATE TH	REOF	230	. NAME OF CEMET	ERY OR	CREMATORY		23d. LC	CATION (City or	Town)	(County) (Stot	e)
	Bu	REMOVAL (Specify)	9-1-6	7	1	Parklaw	n C	emetery		Roc	kville	. Mar	yla	and	
	24.	FUNERAL DIRECTOR ADDRESS						2So.	REC'D	BY REGISTE	RAR 2Sb.	REGISTRAR'S	IGNATU	RE	
	KL	BERT A	• FUMPTIRE	, T 3 E	eln	esua, r	ici I y	DATE	EAU (631	1967	Jelian	cas	moge	

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-bwa real	4			TOPICS AND SERVICE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY Mont conere Lunia sti MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b þ hours Ever solina Silven Swins 2 I articon filled i d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? in 72 3557 Joursh Leisure worla Elve YES NO Z completely i 3. NAME OF Month Middle Day Year **OECEASED** OF OEATH atherine 196 7 Lupac (Type or print) executed AGE (In lears | IF UNDER 1 YEAR | IF UNDER 24 HRS. last blynday) | Months | Days | Hours | Min. 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 9. NEVER MARRIED 7. MARRIED and t-emale WIDOWED DIVORCED [yrs. 12. CITIZEN OF WHAT 2 10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) physician pe during most of working life, even if retired) COUNTRY? INDUSTRY and washington. O.C. ouseville death certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remova attending permit. Ther 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address transit permit. (Yes, no, or unkown) (If yes give war or dates of service) Or. Frank the 18. CAUSE OF OEATH [Enter only one cause per line for (a), (b), and (c) INTERVAL BETWEEN n signed by t burial-transit burial, crema ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) be retained by the hospital or attending physician. Conditions, if any, which this certificate has been detached for use as the ble Dept. of Health prior to b gave rise to immediate DUE TO cause (a), stating the underlying cause last. CERTIFICATION WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO F YES [20a. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) MEDICAL 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State) 20d, INJURY OCCURRED 20f. (City or town) TIME OF INJURY Month, Day, Year Q) Hour a.m. While Not While TO FUNERAL DIRECTOR: After director, page 3 should be d should be filed with the State OR ATTENDING at work at work 21. I certify that (I) (this hospital) attended the deceased from and that death occurred at ZP M. from the causes and on the date stated above. saw the deceased alive on \$ 22b. DATE SIGNED 22a. SIGNATURE M.D. Page 4 may PHYSICIAN'S 22d. ADDRESS NAME (Type) NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) BURIAL, CREMATION. 23b. REMOVAL (Specify) REC'D BY REGISTRAR 1267 FUNERAL DIRECTOR ADDRESS 25a. Hunteronn & VR A15 (4) 15M 4-64



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11238 FOR STATE HEALTH DEPT. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Page b. CITY OR TOWN (It autside carparate livits, write RURAL and give neares pwn) MARYLAND c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Prince deloy and 3 1 c. LENGTH OF STAY IN 1b PM3 NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) e. IS RESIDENCE ON A FARM? pencil in Item 18. Give Pages YES NO X Office along with Day Year DECEASED Beth (Type ar print) Luxford none DEATH august 12 1967 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthday) Manths Hours Days Female White -30-65 pages land2 yours ofter death WIDOWED DIVORCED This certificate should be executed within 24 haurs 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) **INDUSTRY** COUNTRY? Maryland

14. MOTHER'S MAIDEN NAME USA Exominer's 13. FATHER'S NAME 72 hours c Carolyn Allen . = IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT e, writing the ward "pending" is farwarded to the Chief Medical (Yes, na, ar unknawn) (If yes give war ar dates af service within Washington Mone 18. CAUSE OF DEATH (Enter anly one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: event \ burial-tronsit ONSET AND DEATH Second and Third Degree Burns IMMEDIATE CAUSE (a) of 80% of Body Surface any Conditions, if any, which gove rise ta immediate cause (o), = DUF TO stating the underlying cause 0 puo remaval. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? the certificate, NO 20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 3 shauld PRIMARY CONTRIBUTING 4 should crematian, ar EXAMINER: CAUSE OF DEATH Deceased infant burned in fire in shed at home when 2De. PLACE OF INJURY (Hame, forme ap 2011 1919) or fown mower and grant grant and are 20d. INJURY OCCURRED 20c. TIME OF INJURY Manth, Day, Year factory, street, affice bldg., etc.) Nat While FUNERAL DIRECTOR: Poge 8/6/67 19 Adelphi, Pr. Geo. Co., Md. at wark please execute at wark Home 21. I certify that I taak charge of the remains described above, held an Autopsy Inspection \ and in my apinian death resulted from: Natural causes Accident Suicide Undetermined manner be retoined CHIEF MEDICAL EXAMINER Heolth priar ta ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE funerol DEPUTY **EXAMINER'S** or county) the 0 Cremalmy YEND TION Max 24. FUNERAL DIRECTOR BY REGISTRAR VR A15ME (5) DATE AUG 1967 6M 1/67

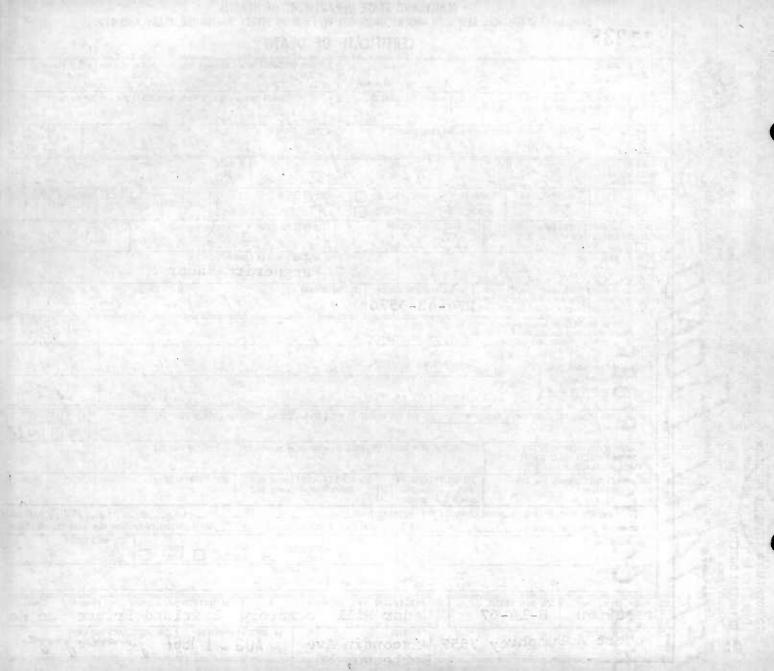
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11238 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived_if institution: Residence before admission) after death MARYLAND ITY OR TOWN (If outside corporate limits write RUKAL and give nearest tawn) TOWN If outside carparate limits, write RURAL and give neorest taw c. LENGTH OF STAY IN 16 c. CITY Deporti e. IS RESIDENC Office along with form hours ON A FARM Stote ofter death. NAME OF DATE Year DECEASED OF DEATH Type or print IF UNDER 1 YEAR * × Months Doys tem 18. Hours event 12. CITIZEN OF WHAT poges I = Examiner's pencil 13. FATHER'S NAME MOTHER'S MAIDEN and 17. INFORMANT permit. removol pending" CAUSE OF DEATH (Enter only one couse per INTERVAL BETWEEN ONSET AND DEATH buriol-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a should word cremation, DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse \Box 0.5 lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? 19. CERTIFICATION please execute the certificate. 0 YES | should be 20o. EXTERNAL CAUSE WAS prior 3 should PRIMARY OF CONTRIBUTING CAUSE OF DEATH. AL EXAMINER: 20c. TIME OF INJURY Month, Doy, Yeor 20e. PLACE OF INJURY (Home, form, Stote factory street, office bldg., etc. moy be retoined for your FUNERAL DIRECTOR: Page designated 21. I certify that I taak charge of the remains described above, held an Autopsy Inspection X the funerol director. deoth resulted from: Natural couses Suicide 🔀 Undetermined monner ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE O DEPUTY **EXAMINER'S** Heolth or county BURIAL, CREMATION 23b. DATE THEREC 23c. NAME OF CEMPTERY OR CREMATORY 23d. LOCATION (City or Town) 0 REMOVAL (Specify) Parklawn Rockville, Buria Maryland Funeral Home-1331 Rockville Pike REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15ME (5) DATEAUG 6M 1/66 Rockville, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE ONTGOMER MARYLAND c. LENGTH OF STAY IN 36 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits write; RURAL and give nearest tawn attending physician and campletely filled in by sermit. Then please remove carban papers. P e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS vent, within 72 YES NO IX Middle NAME OF First 4. DATE Year DECEASED DEATH 19 6 (Type or print 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS SEX 7. MARRIED DATE OF BIRTH 6. COLOR OR RACE birthdoy) Months Dovs Hours or remaval, and in any WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR . BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? OUSEWIF 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Marguerity Bauer 17. INFORMANT 16. SOCIAL SECURITY NO Address WAS DECEASED EVER IN U.S. ARMED FORCES? Caples (Yes, no, or unknown) (If yes give wor or dotes of service) 274-48-3576 cremation, IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-transit p PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) attending physician. DUF TO Conditions, if ony, which gove rise to immediate cause (a), DUE TO far use as the t Health prior tab stoting the underlying couse this certificate has been WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO YES Page 4 may be retained by the hospital or 20o. ACCIDENT WAS UNDERLYING [205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) detached with the State Dept. 20e. PLACE OF INJURY (Home, form, 20d. INJURY OCCURRED (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m foctory, street, office bldg., etc.) Not While TO FUNERAL DIRECTOR: After director, page 3 shauld be d shauld be filed with the State , 19<u>67</u>, that (1) (we) lost . 19 W / to Class 12 21. I certify that (I) (this hospital) attended the deceosed from and that death accurred at 11:55 M, from causes and on the date stoted above. saw the deceased alive on_ 220 SIGNATURE 22b. DATE SIGNED ATTENDING DIRECTOR 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) 23d. LOCATION (City or Town) 23o. BURIAL CREMATION. 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) C REMOVALIBELIED TO 8-14-67 Suitland Prince Geo Md Cedar Hill Crematory ADDRESS 2So. REC'D BY REGISTRAR Pumphrey 7557 Wisconsin Ave 196 VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

		FIGIO	CERTIFICATE	OF DEATH		
		PLACE OF DEATH			here deceosed lived if institution: Res	idence before odmission)
	(Montgomen	MARYLAND	O. STATE May	- Vland b. COUNTY	Instancery
	ŀ	b. CITY OR TOWN (If outside corporate limits,	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outs	side corporate limits, write RURAL and	
		write RURAL and give negrest town)		SILVE	r Spring	15-1
,	(MAME OF HOSPITAL OR INSTITUTION (If not in h	nospitol, give street oddress)	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?
1	7	Nask, Samie Hos	p.	1220 E,	W. Hichway	YES NO
ī		NAME OF First /	Middle	Last ,	4. DATE Month	Doy Year
	_ (Type or print) / / / / / / /		ROWITZ	DEATH AUG.	19 1967
	5.	SEX 6. COLOR OR RACE 7. A		B. DATE OF BIRTH	last birthdov) Montl	DER 1 YEAR IF UNDER 24 HRS.
	/	IEI VYICEIC	IDOWED DIVORCED	Mar, 8/19	03 64 yrs.	
		. USUAL OCCUPATION (Give kind of work done ng most of working life, even if retired)	10b. KIND OF BUSINESS OR	11. BIRTHPLACE (County &	Stote, or foreign country) 12	COUNTRY?
Н	12	Salesman FATHER'S NAME	Mens turnishing	Nomai		0,5.
	13.	FAITHER'S NAME	V +	14. MOTHER'S MAIDEN NA	AME	
	16	WAS DECEASED EVER IN U.S. ARMED FORCES?	16. SOCIAL SECURITY NO. 17. I	NFORMANT	Address	
		s, no, or unknown) (If yes give wor or dotes of serv		1.4		W. Hahray
1		1B. CAUSE OF DEATH (Enter only one couse pe	I I (C	LE MALYO	W112 -1240 F1	INTERVAL BRIWEEN
		PART I. DEATH WAS CAUSED BY:	GI Bleeding			ONSET AND DEATH
		157 X IMMEDIATE CAUSE (a)	DI NIEWING			- The state of the
		Conditions, if ony, which gove) (b)	Panereatic G	ancinama.	¿ metastases	4 mas.
		rise to immediate cause (a), stating the underlying cause				
		lost. (c)				
	2	PART II. OTHER SIGNIFICANT CONDITIONS CONTRI		THE TERMINAL DISEASE COND	DITION GIVEN IN PART 1(o)	19. WAS AUTOPSY PERFORMED?
	CATIO	Heralic encept	helopathy			YES NO
	CERTIFICATION	20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED.	(Enter noture of injury in Po	ort I or Port II of item 18.)	
		(IF EITHER, NOTIFY MEDICAL EXAMINER)				
	MEDICAL	20c. TIME OF INJURY Month, Day, Yeor Hour o.m.		CE OF INJURY (Home, form, ory, street, office bldg., etc.)	20f. (City or town)	(County) (Stote)
	Z	p.m. 19	of work of work			
		21. I certify that (I) (this haspital		death occurred at_	5A.M. fram causes and a	19 <u>67</u> , that (I) (we) last
		saw the deceased alive an 220. SIGNATURE	17 67, and mai	dealli occorred di_		. DATE SIGNED
		Mai Achi	ceal M.C		AED. STAFF DIRECTOR PHYS.	8/19/67
	1	22c. PHYSICIAN'S		22d. ADDRESS	22	MA 209/0
		NAME (Type) MARY, NS	CHNEISER M.	N. 911 Sel	ver specie. s. s.	7.72 -0.70
	230	BURIAL, CREMATION, 23b. DATE THEREOF		CREMATORY	23d. LOCATION (City or Town)	(County) (Stote)
		REMOVAL (Specify) / Burial - 8/19/	67 Sharon Gai		Valhalla, N	Υ.
	24	FUNERAL DIRECTOR B, Daugais	Ey Sous ADDRESS 3501-10	Sezuel 250. REC'D		R'S SIGNATURE
			U water	QC. DATAUG	T IOO!	// //

in by the funeral TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and campletely fil director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban behauld be filed with the State Dept. af Health priar ta burial, crematian, or remaval, and in any event, with Page 4 may be retained by the haspital ar attending physician. VR A15 (4) 25M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11241 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lixed, if institution: Residence before admission) de a. COUNTY g. STATE b. ASOUNTY c. LENGTH c. CITY OR TOWN outside carparate limits, write RURAL and give neorest town) CITY OR TOWN (If outside carpetate limits, write RORAL and give neorest town) d. NAME OF HOSPITAL OR INSTITUTION (If nat in Hospital, give preet address) filled in d. STREET ADDRESS IS RESIDENCE ON A FARM? 72 YES NO C 3. NAME OF ittle FIRST THE MINDLE DATE Yeor Month Dov DECEASED (Type or print) DEATH 0 S. SEX 6. COLOR OR RACE 7 MARRIED B. DATE OF BIRTH 9. AGE (In years FUNDER I YEAR IF UNDER 24 HRS NEVER MARRIED ove last birthday) Months Dovs Haurs WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind af wark dane 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or fareign country) during most of working life, even if retired) INDUSTRY COUNTRY? physician ren please ease 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAMI or remayal. 1de v WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no. ar unknown) (If yes give wor or dotes af service) permit. SAME AS ITEN M. MARSHALL crematian, 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c),) INTERVAL BETWEEN signed by the burial-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if any, which gave rise to immediate couse (a). DUE TO stating the underlying cause as the priar ta last WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) af Health NO this certificate far 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED (City or tawn) 20c. TIME OF INJURY Manth, Day, Year 20e. PLACE OF INJURY (Hame, farm, (County) (State) Haur a.m. factory, street, affice bldg., etc.) Nat While at wark ot wark After 21. I certify that (I) (this haspital) attended the deceased fram. 1967, that (1) (we) last 7, and that death accurred at 5 34M, from causes and an the date stated above. saw the deceased alive on 22o. SIGNATURE 22b. DATE SIGNED ATTENDING directar, page 3 shauld be filed v M.D. PHYS DIRECTOR PHYS 22d. ADDRESS 22c. PHYSICIAN'S FUNERAL ST. W.W. Wash PEABOD 1234 NAME (Type) JOSEP 23a. BURIAL, CREMATION DATE THEREOF 23c. NAME 23d. LOCATION (City or Tawn) (County) (State) REMOVAL (Specify) WITLAND 2Sa. RECO BY REGISTRAR FUNERAL DIRECTOR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 Charles DATE AUG Wol- Good Hope

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH JUVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
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3.	NAME DF		Inite H	Middle	Last	4. DATE	Month	YES Day	Year
	(Type or print)	MINNI	E G		Martin	OF DEATH	8	27	1967
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		EVER IN U.S. ARMED F	of service)		7. INFORMANT	9	Address		mont
	NO		7/	3-56-4107	Admission	Record	1 B. S.	rough Nur.	sing Home
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-	underlying cau	se last.	(c)	merole	ed are	rise	Keros	s ge	ars
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CERTIFICATION	OR CONTRIBUT	ING CAUSE OF DE	ATH INER)	ESSATE HOW WHOM: O	COUNTED (CITCH HALLIO				
CAL	2Dc. TIME OF	INJURY Month, Day,			PLACE OF INJURY (Home, factory, street, office bidg.,	farm, 2Df. (City	y or town)	(County)	(State)
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			pital) attende	d the deceased from.		1965, to 8			(I) (we) last
	saw the de	ceased alive on	7-3/	1967, and	that death occurred at	M, from	the causes and		
	M	7 RX	5 2 410	61-092012	M.D. PHYS.	MED. DIRECTOR	STAFF PHYS.	3-27	-67
	22c. NAME (T	AN'S			22d. ADDRESS	(, =	n	
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238	REMOVAL (SI	MATION, 23b. DATE	HEREOF	23c. NAME OF CEMEN	ERY OR CREMATORY	Parti	TION (City, town o	EP 7	(State)
24	FUNERAL DIR	ECTOR /	1	ADDRESS	1 mesa. RI	EC'D BY REGISTR		TRAR'S SIGNATI	RE
	Ornest & Tacher Lenther DATE (SEP 1 1961 Gloves Judge								

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west Va. Montgomery Silver Spring Syen Smith 17220 New Hangsborn Ave. Martin 8 27 162 1-18-1884 83 Virginia U.S.A. bouse wife -Judy A. Moore Briant Luke Graham Admission haved I B. sound house in acite coming acquirem for me arbenistate front de wen years generalized artemacherines apress General general determenten det see J. C. S. Starter 196. 18 20 61 00 BURTONSVILLE, MD. Energy & Fredering First with the war from from

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11244 11243 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY Montgomery o. STATE b. COUNTY MARYLAND Pennsylvania b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b tely filled in by the bond of the papers. Page, within 12 haurs a Uniontown Bethesda 34 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) 20014. e. IS RESIDENCE ON A FARM? d. STREET ADDRESS The Clinical Center, Bethesda, Maryland 21 Pershing Court NO IX YES and campletely fi 3. NAME OF 4. DATE First Month Year Doy DECEASED (Type or print) 1967 Matthews August 31 James (None) DEATH and in any every IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED lost birthdoy) Months WIDOWED DIVORCED 25 January 1916 Male Negro 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) INDUSTRY COUNTRY? attending physician permit. Then please Pennsylvania Produce USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, crematian, ar remaval, Charles Matthews Mary Belle Gross 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANTThe Medical Record ddress 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dates of service) The Clinical Center, Bethesda, Maryland Yes 178-07-0527 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH Septicemia with peritonitis IMMEDIATE CAUSE (o) **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the hospital ar attending physician. DUF TO Conditions, if ony, which gove 1 year Chronia glomerulonephritis rise to immediate couse (a), DUF TO stoting the underlying couse as the Severe coronary arteriosclerosis vears 19. WAS AUTOPSY has PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? Rheumatoid arthritis; lymphoma YES K NO certificate ar 20o. ACCIDENT WAS UNDERLYING TO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED (County) Hour o.m. foctory, street, office bldg., etc.) Not While of work of work 21. I certify that (1) (this haspital) attended the deceased fram 28 July , 1967, to 31 August, 1967, that (1) (we) last saw the deceased glive an 31 August 19 67, and that death accurred at 1:20 M, fram causes and an the date stated above 22o. SIGNATURE 22b. DATE SIGNED directar, page 3 shauld be filed v M.D. DIRECTOR 1 Sept. 1967 PHYS. 22d. ADDRESS The Clinical Center, National 22c. PHYSICIAN'S TO FUNERAL NAME (Type) Institutes of Health, Bethesda, Md. Daniel Ein. M.D. 230. BURIAL CREMATION, REMOVAL (Specify) 23c. NAME OF CEMETERY OR CREMATORY 23d. LQCATION (City or Town) (State) DATE THEREOF (County) 250. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUMERAL DIRECTOR Michaelle

MARYLAND STATE DEPARTMENT OF HEALTH

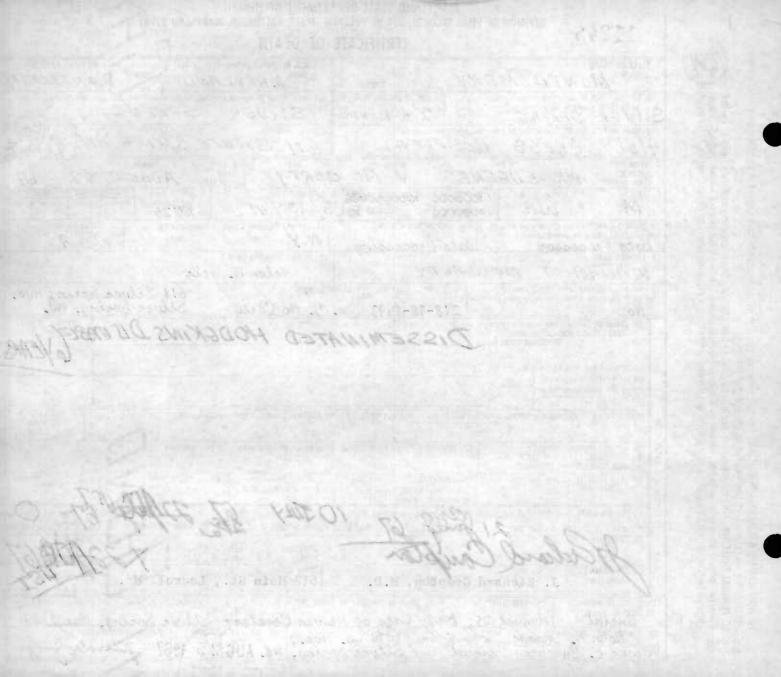
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11244 CERTIFICATE OF DEATH 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) ether tilled in by the funero arbon papers. Pages I and Maryland Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b 4 months 8 days Hyattsville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Cross Hospital 6902 24th Avenue YES NO drbon 3. NAME OF Middle 4. DATE Year Dov DECEASED Willard Mank Anaust 19 67 (Type or print) DEATH requires that the death certificate be executed 5. SEX 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED 8 DATE OF BIRTH NEVER MARRIED ottending physician ond compermit. Then pleose remove lost birthdoy) Months Dovs Hours Male White July 8. 1918 DIVORCED WIDOWED 10o. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even irretired) Southern Pacific ondi Georgia 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME John J. Mank Mande Parmley IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT 6902 24th Huenne (Yes, no, or unknown) (If yes give wor or dotes of service) 0 422-16-7113 Mank Justisville, Maruland 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH buriol-tronsit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) signed by DUE TO Conditions, if ony, which gove rise to immediate cause (o). DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been the lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES NO the hospital or Por 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Not While ot work L ot work 21. I certify that (I) (this hospital) attended the deceased from 1960 to 1960, that (I) (we) last sow the deceased glive on 1967, and that death accurred at 106M, from couses and an the date stated above. aug. 19 67 that (1) (we) last TO HOSPIIAL ON Page 4 may be retained by sow the deceased alive on Que 22b. DATE SIGNED 220 SIGNATURE ATTENDING DIRECTOR M.D. PHYS 22d. ADDRESS 22c. PHYSICIAN'S University Blud. Boris Rabkin. M. D. 1019 NAME (Type) director, should b 23o. BURIAL CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Lincoln Cemetery Prince Georges Co 250. REC'D BY REGISTRAR VR A15 (4) DATE 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

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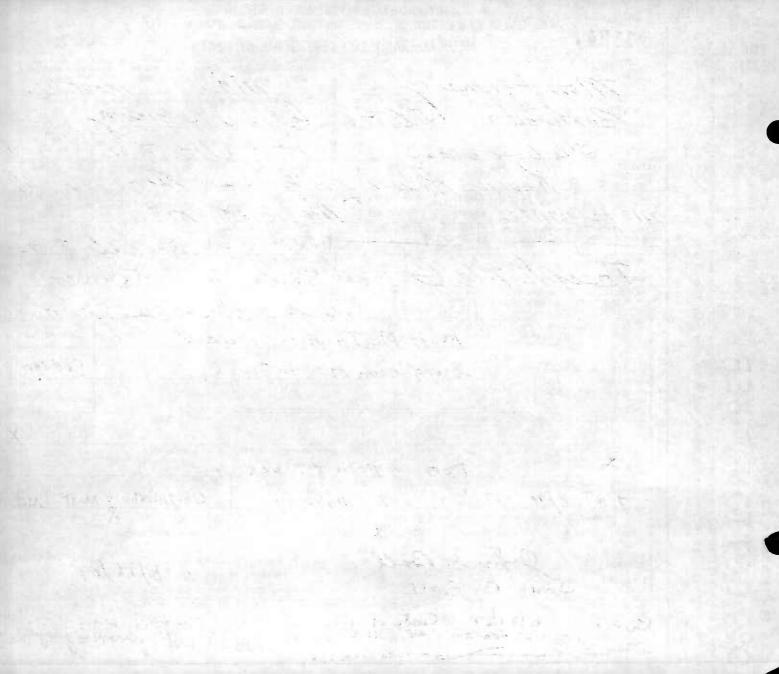
MARYLAND STATE DEPARTMENT OF HEALTH



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* 7 ~ -	CERTIFICATION	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II of item 18.) PRIMARY OF DEATH.	
INER: ne certifi shauld files. 3 shauld tion, ar	MEDICAL	20c. TIME OF INJURY Month, Day, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (Col	unty) (Stote)
L EXAMINER: ecute the cert Page 4 shauld ar your files. R: Page 3 shau Il, cremation, a	WE	Hour o.m. p.m. 19 While Not While of work foctory, street, office bldg., etc.)	
J. Star P. P. C. P.		21. I certify that I took charge of the remains described above, held on Autopsy, Inspection, Inquiry,	ond in my opinion
UTY MEDICAL Iny, please executed director. Properties of the precipitation of the prior to burial,		death resulted from: Noturol couses X, Accident , Suicide , Homicide , Undetermined monner	
,		SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER	22. DATE SIGNED
O DEPUTY MEDICA necessary, please e, the funeral director. S may be retained O FUNERAL DIRECTOR		EXAMINER'S NAME (Type) John G. Ball DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county)	
O DEPU necessa the fun 5 may 1 O FUNEI Health	230	BURIAL CREMATION 236 DATE THEREOF 236 NAME OF CEMETERY OR CREMATORY 236 LOCATION (City or Town)	(County) (State)
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VR A15ME (5) 6M 1/67	Ty	FUNERAL DIRECTOR Son Wheeler Funeral Home-1331 Rockville Pike Rockville Paryland ADDRESS 250. REC'D BY REGISTRAR 9 266 PROSISTRAR 9 266 PR	Ciarles Judge
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DERT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY 10 delay 3 b. CITY OR TOWN (If outside corporate limits c. LENGTH OF STAY IN 16 pup PM3 d. NAME OF HOSPITAL OR INSTITUTION. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? (If not in hospital, give street oddress) in Item 18. Give Pages YES NO V This certificate shauld be executed within 24 haurs after death. 3. NAME OF DATE Doy Year DECEASED OF DEATH (Type or print) alang S. SEX 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH AGE (In years **IE UNDER 1 YEAR** IF UNDER 24 HRS lost birthday Months Dovs Hours event within 72 haurs after death WIDDWED DIVORCED ward "pending" in pencil in Item 18 the Chief Medical Examiner's Office 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY burg 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER JUS. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no. or unknown) left yes give wor or dotes of service) 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c). INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) please execute the certificate, writing the ward DUF TD Sudden any Conditions, if ony, which gove rise to immediate couse (a). be farwarded ta .= DUE TO D. stoting the underlying couse and 19. WAS AUTD PSY PEREOR MED? PART II. OTHER SIGNIEICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) removal, NO X pe 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 3 shauld 0 PRIMARY OF CONTRIBUTING CAUSE OF DEATH. shauld cremation, 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) 20c. TIME OF INJURY Month, Doy, Year (County) (Stote) Not While factory, street, office bldg., etc.) may be retained far yaur FUNERAL DIRECTOR: Page Gaithersbuig Mint. ot work 21. I certify that I taok charge at the remains described above, held an Autopsy Inspection 🔀 and in my opinian death resulted fram: Suicide Accident X Hamicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED priar ASSISTANT MEDICAL EXAMINER SIGNATURE O DEPUTY DEPUTY MEDICAL EXAMINER **EXAMINER'S** Health OHN NAME (Type) Address (Street, city, town, or county) 23o. BURIAL CREMATION 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 0 REMOVAL (Specify) Gare of HODE DODRESS 316 24. FUNERAL DIRECTOR GARTNER FUNERAL VR A15ME 6M 1/67 Gzithers



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y the rear this detact	EDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While Not While 2 work 2 w	(State)
t: Aft buld buld be he St	Z Z	21. I certify that (I) (this hospital) attended the deceased from [Ma] 19 6 to [Ma] 7, 196	, that (I) (we) last
Show with t	0	Saw the deceased anve on the same of the s	date stated above
DIR DIR age	7	Ralend I that adm M.D. ATTENDING MED. STAFF I Couly	19-61
NERAL NERAL Idobe	ring	NAME (Type) OBERT T. THIBADEAU KOCKVILLE MT. 20	0852
Should should be	3 23	DEMOVAL (Procify)	y) (State)
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11252 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY MONTGOMERY b. COUNTY MARYLAND b. CITY OR TOWN (If autside corporate limits. c. LENGTH OF STAY IN 1b. c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest tawn) write RURAL and give negrest town) eose remove carbon papers. Pag pnominany event, within 72 hours D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? SANITARIUM YES NOW 3. NAME OF 4 DATE Day Year DECEASED OF DEATH MARIES (Type or print) MES 196 S. SEX 6. COLOR OR RACE 7. MARRIED IF UNDER 24 HRS 9. AGE (In year **NEVER MARRIED** last birthday) Months Dovs Haurs WIDOWED DIVORCED 1Da. USUAL OCCUPATION (Give kind of work done 1Db. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) Wash Terminal 2WITCHTENDER AShinaton 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Marie WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor ar dates of service) 719-03-1717 18. CAUSE OF DEATH (Enter only one cause per line-for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gove rise ta immediate cause (a), DUE TO stoting the underlying couse lost. 00 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) 19. WAS AUTOPSY PERFORMED? ron Chit NO X 2Da. ACCIDENT WAS UNDERLYING 2Db. DESCRIBE HOW INJURY OCCURRED (Enter hature of injury in Part I or Part II af item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2De. PLACE OF INJURY (Home, farm, 2Dc. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20f. (City or town) (County) (State) Haur a.m. factory, street, office blda., etc.) TO FUNERAL DIRECTOR: After at wark 21. I certify that (I) (this haspital) attended the deceased fram Man saw the deceased alive an 4 aug 1967, and that death occurred at 11 20 M, fram causes and an the date stated above. 220. SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS. M.D. DIRECTOR 22c. PHYSICIAN 22d. ADDRESS NAME (Type) 23o. BURIAL CREMATION 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) REMOVAL (Specify) 9/2/67 Mt. Olivet Cemetery Wash. D.C. Mt. Ralni Isa REC'D BY REGISTRAR Funeral ADDRESS 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 Home Inc. Maryland

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10 1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
FOR STATE	11252 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	53
HEALTH DEPT.	1. PLACE OF DEATH O. COUNTY 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence be on STATE on	
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form form	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS Apt. 422 School Connecticut Ave.	e. IS RESIDENCE ON A FARM? YES NO
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rs afte 18. Gi e olonç 2 with 1th.	S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years includey) Months Doy VYS.	
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se execute ctor. Poge vou for you burial, crem		nd in my opinion
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TO DEPU necesso the fun 5 may 10 FUNEI	230. BURIAL, CREMATION, REMOVAL (Specify) 8/21/67 FT. LINCULN CEM. 23d. LOCATION (City or Town) (Court REMOVAL (Specify)) 8/21/67 FT. LINCULN CEM.	(Stote)
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1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
FOR STATE	11253 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11254
HEALTH DEPT.	1. PLACE OF DEATH o. COUNTY Alontgenery. MARYLAND 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before odmission) o. STATE D:Sfirst of County bis
f any delay is 1, 2, and 3 ta m PM3. Page Department af	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sethesda. c. LENGTH OF STAY IN 1b C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Was hington.
th. If on form I	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) Restmon Sonitorium d. STREET ADDRESS 1301 Mass Avenue NW ON A FARM? YES IN O X
within 24 haurs after death. I pencil in Item 18. Give Pages caminer's Office along with fa le pages land 2 with the State of in any event within 72 hay	3. NAME OF DECEASED (Type or print) Gige/12- H, Middle Wentgenzery. Of Death August 5, 1967 19
haurs after tem 18. Giv Office alang and 2 with	5. SEX 6. COLOR OF RACE 7. MARRIED NEVER MARRIED DIVORCED DIVORCED B. DATE OF BIRTH 9. AGE (In yeors last birthdoy) Windowed Widowed Divorced Months Doys Hours Min.
thin 24 haurs encil in Item 18 miner's Office o pages Land 2 v in any event	10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11c. BIRTHPLACE (Stote or foreign country)
d within in pencil Examinate File pagand in	LOUIS- GOODWILLIG - Regina-Lowenstein. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address PT.
be executed "pending" ii nief Medical xnsit permit. ar remaval,	(Yes, no, or unknown) (If yes give wor or dotes of service) none Dr. Howard. H. Mongomery-3326 Stuyvesan
d be exidence of the contract	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brenchiol Pneumonia - Sussiand Death
INER: This certificate should be executed within 24 hours after death. If we certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, should be farwarded to the Chief Medical Examiner's Office along with farm files. 3 should be used as a burial-transit permit. File pages I and 2 with hestine beint, priar to burial, cremation, ar remaval, and in any event within 72 hours.	Conditions, if ony, which gove rise to immediate couse (a), stating the underlying couse lost. (b) Organic Brain Snythome Years (b) DUE TO (c)
nis certifi tte, writin s farward se used a to burial,	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).
MINER: This certificate, writh the certificate, writh a should be farworn files. e 3 should be used gent, prior to burion	PERFORMED? YES NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) PRIMARY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.)
XAMINEI ute the ce ge 4 shau yaur files Yage 3 sha d agent, j	20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19 20d. INJURY OCCURRED While of work of
MECKAL EXAMINER: please execute the certi al director. Page 4 shauld retained for your files. L DIRECTOR: Page 3 shaul its designated agent, pri	21. I certify that I taak charge of the remains described above, held an Autapsy, Inspection, Inquiry, and in my apinion death resulted fram: Natural causes, Accident, Suicide, Hamicide, Undetermined manner
UTY MEC. Inty, please ereal director be retained RAL DIRECT or its design	ACTUAL SIGNATURE SIGNATURE SIGNATURE STAMMARED'S ACTUAL CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER EVAMINED'S 22. DATE SIGNED
o DEPUTY MELLAI EXAM necessary, please execute the funeral directar. Page 45 may be retained for your o FUNERAL DIRECTOR: Page Health or its designated age	NAME (Type) John G. Ball, M. D. Address (Street, city, town, or county) 230. BURIAL (REMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR (REMATORY 23d. LOCATION (City or Town) (County) (Stote)
	Removal (Specify) 8/8/67 Rock Creek Cemetery Washington, DC 24. FUNERAL DIRECTOR The S. H. Hines Co. ADDRESS 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE.
VR A15ME (5) 6M 1/66	Washington, D. C. DATE AUG 8 1967 fclientes Judge

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1	-	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, M	ARYLAND
h. 2ªd. h.		11254 CERTIFICATE OF DEATH	1255
death.	1.	PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Re a. STATE / b. COUNTY	asidence before admission
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filled in papers. Pin 72 hours	1	d. NAME OF HOSPITAL OR ANSTITUTION (If not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE
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executed within and completely remove carbon n any event, with	5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER)	
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	dur	USUAL OCCUPATION (Give kind of work done lob. KIND OF BUSINESS OR ling most of working life, even if retired) 10b. KIND OF BUSINESS OR ling most of working life, even if retired) 11. BIRTHPLACE (County & State, or foreign country) 12. CI	TIZEN OF WHAT UNTRY?
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aw requires that the death certificate be extending physician. has been signed by the attending physician as the burial-transit permit. Then please reprior to burial, cremation, or removal, and in in an extending the control of the		August Palm Adelia Belle Atwend	
th contract	15 (Ye	. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITY ND. 17. INFORMANT 4640 Saddress es, no, or Linkown) (If yes give war or dates of service)	st. ir.u
e death c the atten it permit.	2	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).]	I INTERVAL BETWEEN
uires that the deal g physician. n signed by the al burial-transit pern burial, cremation,		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circle processed. accident.	ONSET AND DEATH
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requires the ding physic been sign the burial or to buria		gave rise to immediate (b)	
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The lan or att or att hat hat use a salth p	CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPS' PERFORMED?
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PHYSICIAN the hospita this certife detached f		20a. ACCIDENT WAS UNDERLYING \(\) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING \(\) CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
PHYSICIAN: The late hospital or at this certificate hetached for use to Dept. of Health	MEDICAL	20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (Court factory, street, office bldg., etc.)	nty) (State)
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		21. I certify that (I) (this hospital) attended the deceased from	, that (I) (we) la ne date stated abov
OR AT be replied in the property of the proper		22a. \$\frac{1}{2}\text{DA}\text{T} \text{DA}	ATE SIGNED
PITAL OR 4 may be ERAL DIR or, page 1 be filed		22c, PHYSICIAN'S	my 61.
ro Hospital Page 4 may o FUNERAL director, pa should be fi		NAME (Type) J. W. VOZLI MN) 1102 BRINTFURD 18	115-7-7.
TO HOSPITAL OR ATTEN Page 4 may be retaine TO FUNERAL DIRECTOR: director, page 3 shoul should be filed with th	232	REMOVAL (Specify)	0- 1
	24	JURIAN 8/17/67 HRUNGTON NAT. CEM. HRUNGTON VIK FUNERAL DIRECTOR ADDRESS ADDRESS 25a. RECID BY REGISTRAN, 25b. PERISTRAN AUG 1969	SSIGNATURE
VR A15 (4) 15M 4-64	7	Joseph Grawler's Son's Inc. Wish. DATE. DATE	es Judge

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MARYLAND STATE DEPARTMENT OF HEALTH 11255 DIVISION OF VITAL RECORDS, 301, W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) a. COUNTY o. Swix Maryland b. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside carparate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) write RIJRAL and give nearest tawn) The law requires that the death certificate be executed within 24 haurs 4 days Accokeek d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS Route #1 Box 285 Naval Hospital YES NO X NAME OF and campletely remove carbon First Middle 4. DATE Last Month Day Year DECEASED 1967 Bruce Burton MULLER 8 George (Type or print) DEATH S. SEX 6. COLOR OR RACE B. DATE OF BIRTH 7. MARRIED NEVER MARRIED 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. lost birthdoy) Male Cauc 19 Dec 1920 and in any WIDOWED DIVORCED and 10b. KIND OF BUSINESS OR 10a. USUAL OCCUPATION (Give kind of work dane 11. BIRTHPLACE (County & State, ar fareign country) 12. CITIZEN OF WHAT physician a during most of werking COUNTRY U.S.A life eyen if retired) INDUSTRY USN Bristol, Va. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remaval, Frederick Muller Bessie Jones 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no ar unknown) (If yes give war or dates af service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address Accokeek, Md. permit. 225-03-3795 Juanita P. Muller Rt#1, Box 285 Accokek/ No/ crematian, 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (0) Myocardial Infarction, Acute O HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if any, which gave Arteriosclerotic Coronary Vascular Disease, rise to immediate couse (a), DUE TO Severe far use as the l Health prior to b stating the underlying cause PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? CERTIFICATION NO certificate 20g. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, (City or town) (County) (State) Hour o.m. factory, street, affice bldg., etc.) Not While at wark at wark **DIRECTOR:** After 3 August , 1967 to 7 August , 1967, that (1) (we) lost 21. I certify that (I) (this haspital) attended the deceased fram. be filed with the and that death accurred at 9:15PM, from causes and on the date stated above. 7 August saw the deceased alive an 1907 22a. SIGNATURE 22b. DATE SIGNED **ATTENDING** STAFF PHYS. K 8 Aug., 1967 M.D PHYS. 22d. ADDRESS PHYSICIAN'S O FUNERAL NAME (Type) P:T: KIRCHNER Naval Hospital, Bethesda, Md. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town)
Arlington, Va. 23a. BURIAL CREMATION. 23b. DATE THEREOF (County) (State) Arlington, National REMOVAL (Specify) Aug. 11-1967 REGISTRAR'S SIGNATURE WDC ADDRESS 2Sq. REC'D BY REGISTRAR 2Sb. VR A15 (4) 25M 1/67 Funeral Home 1661 Good Hope Rd. S.E. 1967

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death funeral deo PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY b. COUNTY tely filled in by the fun bon papers. Pages 1 within 72 hours after ONTGOMER MARYLAND b CITY OR TOWN c. LENGTH OF STAY IN 1b. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (If outside corporate limits write RURAL and give nearest town! SILVER d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADORESS IS RESIDENCE ON A FARM? YFS NO [Middle carbon NAME OF 4. DATE First Lost Month Doy Year completely DECEASED event, DEATH 196 Type or print) S. SEX AGE (In years IF UNDER 1 YEAR IF UNDER 24 HR 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED remove last birthdoy) Months Dovs Hours WIDOWED DIVORCED and in any puo 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? GLOVE 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME or removal, RMAN 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yeş,,no, or unknown) (If yes give war or dates of service) cremotion, CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN buriol-tronsit 11000 9h IMMEDIATE CAUSE (o) 'O HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 moy be retained by the hospital or attending physician. DUE TO buriol Conditions, if ony, which gove 26 V 01 675 J 0 47/11 201 73 rise to immediate cause (a), DUF TO stating the underlying cause os the hos been lost. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) WAS AUTOPSY PERFORMED? NO this certificate 10 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Year Hour o.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) While Not While foctory, street, office bldg., etc.) of work ot work TO FUNERAL DIRECTOR: After 21. 1 certify that (1) (this haspital) attended the deceased fram. 1967, that (1) (we) las _, 19 and that death accurred at 2:30AM, from causes and an the date stated above saw the deceased alive an 22o. SIGNATURE 22b. OATE SIGNED MED. DIRECTOR STAFF PHYS. ATTENDING M.D. PHYS. PHYSICIAN'S 22d. AODRESS directar, po should be f NAME (Type) 3737 FB63 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL CREMATION. 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify) Cedar Hill emetery Suitland Md. 30.1967 **ADDRESS** 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) Ave. S.S. Md DATAUG Miliane Pumphrey Inc. 8434 ga.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #2d Film CERTIFICATE OF DEATH executed within 24 hours after deoth PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution; Residence before admission) o. COUNTY o. STATE Maryland b. COUNTY Montgomerv MARYLAND Montgomery filled in by the factorial papers. Poges thin 72 hours aft b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b. Silver Spring 2 days Olnev d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS 1071 Ruatan Stre 1 mont e. IS RESIDENCE ON A FARM? New/ Hambahite/ Ave/ Montgomery General Hospital NO Se NAME OF Middle * M First 4. DATE Lost Month Day Year remove carbon DECEASED OF ond in any event, (Type or print) DEATH 19 Marv Murphy 67 nmn S. SEX IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED lost birthdoy) Months WIDOWED TX White DIVORCED 5/29/86 female ond 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR PHYSICIAN: The law requires that the deoth certificate be physicion (COUNTRY? housewife Washington, D.C.

14. MOTHER'S MAIDEN NAME II.S.A 13. FATHER'S NAME removal, August Neibel Anna Aumet IS. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wo or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Olney, Maddress 0 Medical Records of Montg, General Hospt 215-54-7491 no cremation. 1B. CAUSE OF DEATH (Enter only one couse per line for (g), (b), and (c).) INTERVAL BETWEEN signed by the burial-tronsit p PART I. DEATH WAS CAUSED BY NEUHONIA IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse as the Poge 4 moy be retained by the hospital or ottending PART IL DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)-19. WAS AUTOPSY this certificate hos ed for use of Health p PERFORMED? NO 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER State Dept. 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED Hour o.m. foctory, street, office bldg., etc.) of work **DIRECTOR:** After be 21. I certify that (1) (this haspital) attended the deceased from 1967, that (1) (we) last 3 should with the 19 67, and that death accurred at 8:30 pM, fram/causes and an the date stated above saw the deceased alive an 8/1 220. SIGNAZURI M.D. DIRECTOR PHYS. 22d. ADDRESS PHYSICIAN'S FUNERAL NAME (Type) Donald R. Lewis, M.D. Sandy Spring, Nd. director, should be (County) VR A15 (4) 25M 1/67

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	ı	MARYLAND STATE DEP Division of STATISTICAL RESEARCH AND RECORDS, 301		
		11258 CERTIFICATE	22020	
	1.	PLACE OF DEATH o. COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. STATE b. COUNTY Wash. D.C.	1
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress)	d. STREET ADDRESS e. IS RESIDEN ON A FARR	
		NAME OF First Middle	2526 South Dakota Ave., N.E. YES NC Lost 4. DATE Month Doy Year	X
-	5	(Type or pant)	b. DATE OF BIRTH OF DEATH OF	THIR IN
	1	Male Negro WIDOWED DIVORCED 5,	5/12/1901 lost birthdoy) Months Doys Hours	Min
	dui	o. USUAL OCCUPATION (Give kind of work done ring most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & Stote, or foreign country) Saluda, South Carolina 12. CITIZEN OF WHAT COUNTRY? USA	
	13.	FATHER'S NAME Jim Hill	14. MOTHER'S MAIDEN NAME	
	15	. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. IN	INFORMANT Address Who R. Nicholson, 2526 So. Dakota, Av., N	
		IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse lost. Output Cong. Here DUE TO Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse lost. (c)	Port Joiline Polm Elever ONSET AND DEA	TH
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		OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	(Enter noture of injury in Port I or Port II of item 18.)	
	MEDICAL		CE OF INJURY (Home, form, ory, street, office bldg., etc.) 20f. (City or town) (County) (Sto	te)
			t death accurred at Book M, fram causes and an the date stated of	
		22c. PHYSICIAN'S NAME (Type) Dr. Russell Bufalino	D. ATTENDING DIRECTOR DISTAFF PHYS. DIVERSIGNED 22d. ADDRESS 1429 University Blvd. West Silver	7
	230	O. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR FRANCISCO PORTION OF THE PROPERTY OF THE PROP	EREMATORY 23d LOCATION (City or Town) (County) (Stote Saludae, South Caroli	e)
	7	4. EUNERAL DIRECTOR Turneral Hame 3831, Sacre	250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 moy be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and competed filled in by the funeral directar, page 3 should be detached for use as the burial-transit permit. Then please remove carbor papers. Pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremotion, or removal, and in any event, within 72 haurs after death

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11280

1		PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence befare admission)
		a. COUNTY MARYLAND	a. STATE b. COUNTY
	-		MARYLAND Montgomery
	,	b. CITY OR TOWN (If Cutside carparate limits, C. LENGTH OF STAY IN 1b write RURAL and give nearest town)	c. CITY OR TOWN (If Curside carparate limits, write RURAL and give nearest tawn)
		TAKOMA PARK	Silver Spring 151
		d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address)	d. STREET ADDRESS e. IS RESIDENCE
71	W	Pashington Sanitacium & Hospital	10718 Tenbeook Drive YES NO K
		NAME OF First Middle	Last 4. DATE Manth Day Year
	(DECEASED (Type or print) Mollie None	Michalson DEATH 8 11 1967
	S. 3	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED	8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.
		F White WIDOWED DIVORCED	11-21-96 Jost birthday) Months Days Haurs Min.
		. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR	11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT
	duri	ing mast of warking life, even if retired) INDUSTRY	Poland Pace (Cooling & State, or to reight Cooling)
	12	FATHER'S NAME	
	13.		14. MOTHER'S MAIDEN NAME
		JACOb Lowenthal	Jenny Ropolovich
	15.	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17.	INFORMANT Address
	(10	was deceased ever in U.S. akmed PORCES? s, no, or unknown) (If yes give war or dates at service)	Partient's Chart.
		18. CAUSE OF DEATH (Enter only one cause per line for (), (b) and (2)	INTERVAL BETWEEN
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Have	40 cardial Marchen ONSE AND DEATH
		4201 DUE TO	
		Canditians, if any, which gave) (b) Coronar	Thromborn Shis
		rise to immediate couse (a),	
		stating the underlying cause (c)	arten destare 20 years
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	20	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESIDED TO	PERFORMED?
2	ATI	Teneralized averios clero	era; diabeles melleres YES \ NO \
0	CERTIFICATION	20a. ACCIDENT WAS UNDERLYING 12 20b. DESCRIBE HOW INJURY OCCURRED). (Enter pature of injury in Part I ar Part II af item 18.)
	CER	OR CONTRIBUTING □ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
	B		ACE OF INJURY (Hame, farm, 20f. (City or town) (County) (State)
	MEDICAL	Haur a.m. While Not While fo	ictory, street, affice bldg., etc.)
	~	p.m. 19 otwork atwark	
		21. I certify that (1) (this hospitol) attended the deceased fram_	3/2, 1966, to 8/11, 19 4, thor (1) (we) last
		saw the deceased alive on19_67 and th	at death/accurred at M, from causes and on the date stoted abave.
		22g STGNATURE	ATTENDING 22b. PATE SIGNED
		I Jonald W Sallon N	A.D. ATTENDING MED. STAFF BYS. BILLIAN STAFF
		22c. PHYSICIAN'S	22d. ADDRESS 823 University Blvd. West
		CNAMETType) Donald W. Datlow, M.D.	Silver Spring, Maryland
	230	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OF	R CREMATORY . 231. LOCATION (City or Town) (County) (State)
	10	BANDVAL(Specify) 8-13-67 COMMUNITY	
	24	FUNERAL DIRECTOR ADDRESS	250. REC'D 8Y REGISTRAR 7 256 AFGISTRARY SIGNATURE
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MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11261 11262 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY 3 to Page MARYLAND Montgomery Maryland delay b. CITY OR TOWN of autside tarporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) 2, u. P.M3. write RURAL and give nearest town) Olney, Md. 45mins. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) e. IS RESIDENCE farm ON A FARM? Box, 179 Montg omery General Hospital, Olney, Md Give Pages YES NO X 24 hours after death. Office along with 3. NAME OF 4. DATE First Last Month Day Year DECEASED Elias Offutt August 19 67 (Type or print) DEATH John IF UNDER 24 HRS. AGE (In years YEAR S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthday) Manths Doys Hours WIDOWED DIVORCED and 2 10a. USUAL OCCUPATION (Give kind af work dane during most af warking life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT INDUSTRY COUNTRY? haurs after U.S.A Janitor
13. FATHER'S NAME Maryland Chief Medical Examiner's Astro Comm. Lab 14. MOTHER'S MAIDEN NAME pencil be executed within File Elizabeth Randoff Samuel Offutt 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT (Yes, na, or unknown) (If yes give war or dates of service event within No INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per lipe or (a), (b), and burial-transit ONSET AND DEATH PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) This certificate shauld the ward DUE TO any Conditions, if ony, which gove rise to immediate cause (a), icate, writing the be farwarded ta .⊑ DUE TO stating the underlying couse D. pup OS last. remaval, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? certificate, 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) should PRIMARY ar CONTRIBUTING shauld 0 CAUSE OF DEATH cremation, 20e. PLACE OF INJURY (Home, farm, (City or town) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (County) (State) Haur a.m. factory, street, affice bldg., etc.) Nat While may be retained far yaur FUNERAL DIRECTOR: Page please execute at wark at wark 21. I certify that I took charge of the remains described above, held on Autopsy Inspection X Inquiry X ond in my opinion burial, Natural causes Accident Undetermined manner the funeral directar. death resulted from Suicide Homicide CHIEF MEDICAL EXAMINER to ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER priar SIGNATURE DEPLITY MEDICAL FXAMINER **EXAMINER'S** Health Address Super Rith 10 Way or county) BURIAL CREMATION (State) 0 REMOVAL (Specify) MT. ZION CEMETERY MT. ZION, MONTG. MD. 8/5/67 ADDRESS VR A15ME (5)

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. STATE b. COUNTY MARYLAND MonTgamer after death Department b. CITY OR TOWN-(If autside carparate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest tawn) write RURAL and give nearest town) 4 days Silver Spring d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? State Del Office alang with form YES NO in Item 18. Give Pages NAME OF 4. DATE Lost Year DECEASED OF wen 19 (Type or print) DEATH lost birthdoy) IF UNDER IF UNDER 24 HRS. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Months Hours Days WIDOWED DIVORCED and 2) even 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country 12. CITIZEN OF WHAT during most of working life, even if retired)
Lectrical mechanic INDUSTRY COUNTRY? in any onditionina 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME pencil be executed within Gordon Owens Helen U. Powell File WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT 4416 Edgebrook Road permit. (Yes, no, or unknown) (If yes give wor or dotes of service remayal, Bertha Mae Owens ues Korean CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
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CERTIFICATE OF DEATH

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sicia sicia led t al-tr al, c		Conditions if any which gave	
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ATTENDING stained by tl CTOR: After shauld be d ith the State		21. I certify that (I) (this hospital) attended the deceased from	
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The low requires that the death certificate be executed within 24 hours after death. funeral 1 and 2 ter death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution; Residence before admission) Alled in by many papers. Pages 1 una 72 hours after d o. COUNTY o. STATE b. COUNTY Olney MARYLAND Monicomer MARYLAND MONTGOMERY b. CITY OR TOWN (If outside corporate limits, ourself write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) SWINDSWERRING SILVER SPRING d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? D. O. A. 2501 NORBECK ROAD MONTGOMERY GENERAL HOSPITAL YES X NO corbon NAME OF First Middle Lost 4. DATE Month Year event completely DECEASED 19 67 (Type or print) ORES Eugene PARKER DEATH AUGUST 15 IF UNDER 1 YEAR IF UNDER 24 HRS SEX 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED remove lost birthdoy) Months Dovs Hours EXAMI WHITE WIDOWED DIVORCED 6-24997 ond in ony MALE 70 puo 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) COUNTRY? **INDUSTRY** PLASTERER USA RETIRED TEXAS CAL 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME _ removal, WILLIAM PARKER 6----BOYD ED I 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dates of service Dorothy 00 No None cremation, CAUSE OF DEATH (Enter only one couse per time for (o), (b), and (c) INTERVAL BETWEEN AP burial-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Ш 0 DUE TO signed 1 buriol, Conditions, if ony, which gove rise to immediate couse (a), DUE stoting the underlying couse prior to l attending the last. BY 05 WAS AUTOPSY PERFORMED? PART II. OMER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ш EASI NO certificate OR ATTENDING PHYSICIAN: 200 ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) by the hospital OR CONTRIBUTING CAUSE OF DEATH Stote Dept. of EL (IF EITHER, NOTIFY MEDICAL EXAMINER) 00 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour om. factory, street, office bldg., etc.) S Not While ot work L I certify that (1) (this haspital) attended the deceased fram Poge 4 moy be retained director, page 3 should should be filed with the ED saw the deceased alive an 2 1967, and that death accurred at 504M from causes and on the date stated above DIRECTOR: AR 220. AGNATURE MED. DIRECTOR ATTENDING W M.D. PHYS. PHYS. 22d. ADDRESS PHYSICIAN'S O FUNERAL NAME (Type) DONALD R. LEWIS, M.D. MEDICAL CENTER-SANDY SPRING. MD. 23c NAME OF CEMETERY OR CREMATORY 23o. BURIAL CREMATION. 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Rock Preek Cemetery Aug 11 Burial 25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67 MANE AU Tuneral Home Silver Spring. unintell

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MARYLAND STATE DEPARTMENT OF HEALTH 11266 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11265 CERTIFICATE OF DEATH papers. Pages i circ PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) o. COUNTY MONTGOMERY MONTGOMERY MARYLAND OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, write RURAL and one nearest town) CHASE e. IS RESIDENCE ON A FARM? NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) NO TH FNOX NAME OF Middle DATE Year Doy DECEASED OF DEATH HUGUST (Type or print) 7. MARRIED 9. AGE (In years NEVER MARRIED remove Dovs Hours and in ony WIDOWED DIVORCED 10b. KIND OF BUSINESS OR USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT most of working life, even if retired) STRICT CLUMEIS FATHER'S NAME 14 MOTHER'S MAIDEN NAME or removol, FMMA HUYETT RIKER HORNTON 16. SOCIAL SECURITY NO. 17. INFORMANT (If yes give wor or dates of service cremation, INTERVAL BETWEEN ONSELLAND DEATH CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) buriol-tronsit PART I. DEATH WAS CAUSED BY ABDOMINAL AORTIC IMMEDIATE CAUSE (o) Poge 4 moy be retained by the hospital or ottending physician. DUE TO prior to buriol. Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse the lost as 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) NO TO certificate p 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) be filed with the State Dept. 20e, PLACE OF INJURY (Home, form, (Stote) 20d. INJURY OCCURRED (City or town) (County) 20c. TIME OF INJURY Month, Doy, Year Hour o.m foctory_street, office bldg., etc.) 21. I certify that (1) (this haspital) attended the deceased fram JULY 29 1967, to Aug 11 1967, that (1) (we) last 1967, and that death accurred at 1.50AM, from causes and an the date stated above. saw the deceased glive on JULY 29 22b. DATE_SIGNED 22o. SIGNATURE ATTENDING PHYS. MED. DIRECTOR M.D. 276 -1965T. N.W. 22c. PHYSICIAN'S NAME (Type) directar, should be DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) BURIAL, CREMATION, Cremation Cedar Hill Crematory 250. REC'D BY Suitland REGISTRAR PAR 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67 Marley Joseph Gawler's Sons, Inc. Wash., D.C.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY Montgomery MARYLAND Maryland Montgomery within 72 hours after b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn)
Silver Spring c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) Silver Spring e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS = 2209 Quinton Rd. Holy Cross Hospital YES NO 4. DATE Month NAME OF Middle Year DECEASED August 19 67 (Type ar print) DEATH the death certificate be executed IF UNDER 24 HRS DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED birthday) Hours 11/15/81 White WIDOWED X DIVORCED Male and in an rece 12. CITIZEN OF WHAT 10a, USUAL OCCUPATION (Give kind af wark dane 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? attending physician permit. Then please during most of working life, even if retired)
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S FOR STATE HEALTH DEPT. I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) COUNTY MARYLAND ote Deportment CLENGTH OF STAY IN 15 d STREET ADDRESS INSTITUTION (If not in hospital, give street address) e. IS RESIDENC form ON A FARM in Item 18. Give Pages This certificate should be executed within 24 hours ofter death. 3 NAME OF OF DEATH DECEASED Office along DATE OF BIRTH AGE (In years lost birthdoy) Months Dovs death. WIDOWED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT durba prost of working life, even if retired) within 72 hours ofter Examiner's 13. FATHER'S NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 60144A (If yes give wor or dotes of service 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) buriol-tronsit PART I. DEATH WAS CAUSED BY event IMMEDIATE CAUSE (0) Bronchopneumonia writing the word DUE TO ony Injuries, multiple, severe due to auto accident Conditions, if ony, which gove rise to immediate couse (o), forwarded to = DUE TO stoting the underlying couse OS lost 19. WAS AUTOPSY PERFORMED?

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11268 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission, 2, and S. Page o. COUNTY b. COUNTY 2 lontaome MARYIAND rince George delay State Department c. LENGTH OF STAY IN 1h. c. CITY OR TOWN IIf autside carparate limits, write RURAL and give negrest tawh? b. CITY OR TOWN (If outside corporate limits write RURAL and give negrest town any e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS le certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 's should be farwarded to the Chief Medical Examiner's Office along with farm This certificate shauld be executed within 24 haurs after death. If YES NO SE NAME OF Middle 4. DATE Year DECEASED 00 1967 (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR 9. AGE (In years 7. MARRIED **NEVER MARRIED** last birthday) Manths 10-12-0 WIDOWED DIVORCED File pages I and 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (State or foreign country) during mast of working life, even if retired) INDUSTRY COUNTRY? irginia Supervisor 13. FATHER'S NAME 14. MOTHER'S MATDEN NAME WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMAN 16. SOCIAL SECURITY NO burial-transit permit. (Yes, na, ar unknown) (If yes give war ar dates of service (Mrs.Sephie -58-8766 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line (a), ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO any Canditions, if any, which gave rise ta immediate cause (a). E DUE TO stating the underlying couse 0 and last. SD be used 19. WAS AUTOPSY remayal, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? the certificate, NO 20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW NURY OCCURRED. (Enter nature of injury for art I ar Part II af item 18.) 3 shauld 0 PRIMARY ar CONTRIBUTING O DEPUTY MEDICAL EXAMINER: CAUSE OF DEATH cremation, MEDICAL 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) Hour a.m. While Nat While factory, street, affice bldg., etc.) may be retained for your FUNERAL DIRECTOR: Page ot work of work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection X Inquiry and in my opinion Natural causes funeral director. death resulted from Aceident Hamicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER prior SIGNATURE Health Address Breek Giry NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City of Town BURIAL, CREMATION 50 Cedar Hill Cometery Suitland. Md 24. FUNERAL DIRECTOR NA 1 10 Y 1 S ADDRESS 2Sa. REC'D BY REGISTRAR Funeral VR A15ME (5) 6M 1/67 Inc. Home



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MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death death funerol PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY a. STATE b. COUNTY Montgomery Maryland ve corbon papers. Pages 1 event, within 72 hours after MARYLAND filled in by the Tu b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b. c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) write RURAL and give nearest tawn) Forest Hill Gaithersburg 4 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM? Asbury Methodist Home for the Aged, Inc. NO YES 3. NAME OF Last 4. DATE Manth First Day Year DECEASED Gilbert Phelps 1967 Mary August (Type or print) DEATH S. SEX 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. lease remove or 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthday) 83 yrs. Manths W Oct. 14, 1883 WIDOWED X DIVORCED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 1Da. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? U.S.A during most of working life, even if retired)
School teacher INDUSTRY Creswell, Harford Co.Md 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or removal, Robert Jason Gilbert Anna S. Cit IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address 16. SOCIAL SECURITY NO. permit. (Yes, na, ar unknawn) (If yes give war or dates of service Asbury Methodist Home, Gaithersburg, Md. buriol, cremation, 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH signed by the buriol-tronsit p PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Page 4 moy be retoined by the hospital or attending physician. DUE TO Canditions, if any, which gave rise to immediate cause (a), DUE TO stoting the underlying cause this certificate has been State Dept. of Health prior to 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CATION use NO YES 10 2Da. ACCIDENT WAS UNDERLYING 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Hame, farm, (County) (State) 2Dc. TIME OF INJURY Month, Day, Year Not While factory, street office bldg., etc.) at wark 21. I certify that (1) (this hospital attended the deceased from _, that (1) (we) last to and that death accurred at X:10 AM, from couses and an the date stated above. DIRECTOR: saw the deceased alive an 22b. DATE SIGNED 22a. SIGNATURE ATTENDING DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, shauld b 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION, 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify) 8/9/67 Mount Zion Cemetery Harford Co., Md. 0 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67 Meliantes 1967 DATE AUG

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24. FUNERAL DIRECTORRobert A. Pumphrey

ADDRESS

Funeral Home, 7557 Wisconsin Ave., Bethesda, Md DATE All

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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HEALTH DEPT.		PLACE OF DEATH			ere deceosed lived, if institution: F	
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11274 CERTIFICATE OF DEATH signed by the attending physician and campletely filled in by the funeral burial-transit permit. Then please remove carban papers. Pages 1 and 2 burial, crematian, ar remaval, and if any eyent, within 72 haurs <u>ofter de</u>ath law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY b. COUNTY JEFFERSON! Montgomer MARYLAND napoleone b. CITY OR TOWN (If outside corporate limits c. LENGTH OF STAY IN 16 c. CITY DR TOWN (If autside carparate limits, write RURAL and give nearest tawn) write RURAL and give nearest tawn) Wintersville Ohio akoma d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE DN A FARM? NAME OF DATE Day Year DECEASED OF DEATH (Type or print) SEX 4 6. COLOR DRARACE 7. MARRIED NEVER MARRIED last birthday) 26 WIDOWED D DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or fareign country) 12. CITIZEN OF WHAT during mast af warking life, even if retired)
Treasure COUNTRY ? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Morrison Bentis 1604 Neeley 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give war ar dates af service Any Hosts Silver Smalley actors INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) haspital ar attending physician. DUE TO belove arternoscherolic lucas Conditions, if any, which gave rise to immediate cause (a),) care DUE TO stating the underlying cause **IO FUNERAL DIRECTOR:** After this certificate has been directar, page 3 shauld be detached far use as the shauld be filed with the State Dept. of Health priar ta 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NDT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) ATTENDING PHYSICIAN: The . conjestive NO 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (State) Haur a.m. factory, street, office bldg., etc.) Not While 1967, to 8 29 1967 that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased fram_ be retained 19 67, and that death accurred at 130 PM, fram causes and an the date stated above. saw the deceased alive an___ 22a. SIGNATURE 22b. DATE SIGNED TROOSD M.D. PHYS PHYS. TO HOSPITAL Page 4 may b 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) 1 1200 23o. BURIAL CREMATION 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify) Napoleon Ohio rans-Buria Forest Hill 24. FUNERAL DIRECTOR Thomas Ave. 250. REC'D BY REGISTRAR 6- 25b. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 Funeral Home Silver Spring, DATE

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11275 CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) o. COUNTY o. STATE b. COUNTY MARYIAND OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after b. CITY OR TOWN (F outside corporate limits c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If and de corporate limits, write RURAL and give newest town write RURAL one oon papers. Pog within 72 hours in by d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? filled YES NO [and completely f pou 3. NAME OF Middle 4. DATE First Lost Year Doy DECEASED OF and in ony event, 196 > (Type or print) DEATH S SEX COLOR OR RACE AGE (In yeor IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED **NEVER MARRIED** DATE OF BIRTH lost birthdoy) Months Doys Hours WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR . BIRTHPLACE (County, & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) attending physicián permit. Then please INDUSTRY COUNTRY 2 13. FATHER'S NAMI 14. MOTHER'S MAIDEN NAME or removal, 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO (Yes, no eranknown) (If yes give wor or dotes of service buriol, cremation, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN buriol-tronsit PART I. DEATH WAS CAUSED BY ONSET AND DEAT IMMEDIATE CAUSE (o) p be retained by the hospitol or ottending physicion. signed ! DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse os the prior to b has been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? Heolth p NO this certificate 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept. 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) While Not While After ot work ot work 21. I certify that (1) (this haspital) attended the deceased from 20 1962, that (I) (we) lost , and that death occurred at 2PM, from causes and on the date stated above O FUNERAL DIRECTOR: saw the deceased alive on 3 filed with 220 SIGNATURE 22b. DATE SIGNED ATTENDING STAFF MD PHYS. DIRECTOR agad 22d. ADDRESS 4743 Bradley Blvd. Chevy Chase, Md. 22c. PHYSICIAN'S Poge 4 moy Horace W. Bernton, M.D. director, pa should be f NAME (Type) 230. , CREMATION 23b. DATE THEREOF /AL (Specify) REC'D BY REGISTRAR VR A15 (4) 25M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofter death. funeral s 1 and dept PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY TOPE COME N o. STATE MARYLAND the b. CITY DR TDWN (If outside corporate limits c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) papers. rus write RURAL and give nearest town) 60 days in by d. NAME OF, HOSPITAL OR INSTITUTION (If not in hospital, give street address) completely filled in NO X NAME OF Middle DATE Dov Year DECEASED (Type or print) DEATH TUGUST 1967 evel S. SEX 6. CDLDR OR RACE DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED remove last birthday) Manths Doys Hours and in any WIDOWED DIVORCED 82 yrs. and 10b. KIND DF BUSINESS DR 10a. USUAL DCCUPATION (Give kind af work done 1. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT physicion a during gnost of working life, even if retired) INDUSTRY Ohio ibrarian ollege 13. FATHER'S NAME 14. MDTHER'S MAIDEN NAME or removo S. Powell Inknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT permit. (Yes, no, or unknown) (If yes give wor or dotes of service) Campanu -10-9385A None venue cremation, 18. CAUSE OF DEATH (Enter only one couse per line for (d), INTERVAL BETWEEN the burial-tronsit PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) Onune signed 1 DUE TO burial, Conditions, if ony, which gove (b) rise to immediate couse (a), DUE TO stoting the underlying couse for use as the l f Health prior to b be retained by the hospital or attending this certificate has been last. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AUTOPS!
PERFORMED? NO PC 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.) detoched f e Dept. of b OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. Not While foctory, street, office bldg., etc.) Stote ot work of work 1967, that (1) (wet last 21. I certify that (1) (this haspital) attended the deceased fram pluods and that death accurred at 0.45 M Mam causes and on the date stoted obove. TO FUNERAL DIRECTOR: saw the deceased alive on. 1967 22o. SIGNATURE 22b. director, page 3 should be filed PHYS DIRECTOR PHYS TO HOSPITAL Page 4 moy b 22c. PHYSICIAN'S ADDRESS NAME (Type) 23d. LOCATION (City or Town) BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County (Stote) REMOVAL (Specify) Riverside Cemetery etiance 2So. REC'D BY REGISTRAR VR A15 (4) 25M 1/67 MarylandDATEAUG

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH ner 1. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b rs. Pag ver S prina completely filled in e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS 2242 49th St. carbon pap ent within NO X Nsa Home Hithea Woodland YFS executed within NAME DE Month Day Year Middle DATE Lest DECEASED 0F Fredenck August 1967 event Ohn reston DEATH (Type or print) AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months | Days | Hours | Min. 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 9. етпоуе 7. MARRIED NEVER MARRIED Months Days Hours In any and WIDOWER DIVORCED 10e. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR (County & State, or foreign country) 12. CITIZEN OF WHAT physician and physician and physician and the ph **COUNTRY?** certificate be during most of working life, even if retired) INDUSTRY issouri U.S. Coumt .S. A. . Then ple removal, FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending r Virginia William 17. INFORMANT Address 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. After this certificate has been signed by the atten Id be detached for use as the burial-transit permit. e State Dept. of Health prior to burial, cremation, or i death (If yes give war or dates of service) NENT B. Greenley Takema taik 811 Houston INTERVAL BETWEEN CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PHYSICIAN: The law requires that the the hospital or attending physician. ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HES INCUMONIA DUE TO EREBRA-VascuLAn. Conditions, If any, which (b) gave rise to immediate DUE TO VASCULAR DISEASC (a), stating the underlying cause last. (c) CERTIFICATION PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? NO YES DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20a, ACCIDENT WAS UNDERLYING OR CONTRIBUTING (CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL (State) TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) factory, street, office bidg., etc.) Hour a.m. Not While While be retained by at work at work p.m. director, page 3 should the Should be filed with the Should be filed with the Should be filed with the Should be sho 19. 66 21. I certify that-(+) (this hospital) attended the deceased from and that death occurred at \$ 140 PM, from the causes and on the date stated above. saw the deceased alive on. 22b. DATE SIGNED 22a. SIGNATURE STAFF PHYS. DIRECTOR PHYS. M.D. Page 4 may PHYSICIAN'S 22d. ADDRESS 22c. NAME (Type) NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) BURIAL, CREMATION, 23b. DATE THEREOF 23c. REMOVAL (Specify) urial Washi OME TO SE YREC'D BY REGISTRAR FUNERAL DIRECTOR Sons, Inc. Gawler's VR A15 (4) 15M 4-64

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11277 11278 CERTIFICATE OF DEATH death. pup PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY b COUNTY Montgomerv MARYLAND Montgomery filled in by the b. CITY OR TOWN (If outside corporate limits. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b write RURAL and give nearest town) within 72 haurs 18 days Brookeville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Montgomery General Hospital YES NO OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within carban 3. NAME OF Middle Lost 4. DATE Month Doy Year completely DECEASED (Type or print) William. Priebe August DEATH 19 67 S SFX IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 24 HRS remove lost birthdoy) Months Dovs Hours Min. in any 9/15/82 WIDOWED DIVORCED White Malel gud 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) COUNTRY? physician (INDUSTRY. and Farmer II.S.A 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remayal, Fibelkorn Herman Priebe Bertha attending permit. The 17. INFORMANDIney, Md. IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give wor or dotes of service) permit. 577-26-8837 Medical Records of Montg. General Hospt. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
 PART I. DEATH WAS CAUSED BY: JNIERVAL BETWEEN IMMEDIATE CAUSE (o) by DUE TO signed 1 burial, Conditions, if ony, which gove rise to immediate couse (o). DUE TO stoting the underlying couse Page 4 may be retained by the haspital ar attending as the After this certificate has been WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? detached far use te Dept. af Health YES [NO. 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER with the State Dept. 20e. PLACE OF INJURY (Home, form, (City or town) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED (County) (Stote) Hour 'o.m. foctory, street, office bldg., etc.) Not While ot work attended the deceased fram HOG-UST 196 I certify that (1) (this haspital) 6/, that (1) (we) last and that death occurred at 60 M, from causes and an the date stated above FUNERAL DIRECTOR: the deceased alive on 220.7SIGNATURE ATTENDING directar, page 3 shauld be filed v M.D. PHYS DIRECTOR PHYS. 22d. ADDRESS PHYSICIAN'S NAME (Type) Donald Lewis Sandy Spring, Md. 23b. DATE THEREOF 23o. BURIAL, CREMATION, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote REMOVAL (Specify)
Burial 8/14/67 Mt. Carmel 0 Sunshine Mont 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) Francis H. Barber Laytonsville. Md. DATAUG

MELONA KIDNEY TERMINAL. HOWTH. MULTIPLE PHELOMA 3-6 1/2 Supplies and and Birial - 5/11/67 Mt. Camel Exacts H. error Invoniving Ma.